PY A848.2 M678

MEDICAL CARE

in the

PUBLIC ASSISTANCE PROGRAM OF PENNSYLVANIA

REPORT AND RECOMMENDATIONS

of a

Special
Advisory Committee

Pennsylvania Committee on
Public Assistance and Relief

Digitized by the Internet Archive
in 2015

https://archive.org/details/medicalcareinpub00penn

MEDICAL CARE

in the

PUBLIC ASSISTANCE PROGRAM OF PENNSYLVANIA

♦

REPORT AND RECOMMENDATIONS

of a

Special
Advisory Committee
June 15, 1937

Submitted to the
Pennsylvania Committee
on Public Assistance and Relief

-10

PENNSYLVANIA COMMITTEE ON PUBLIC ASSISTANCE
AND RELIEF
APPOINTED BY GOVERNOR GEORGE H. EARLE

HERBERT F. GOODRICH, LL.D., Chairman
Dean of Law School, University of Pennsylvania
Philadelphia

RABBI MAX ARZT
Temple Israel
Scranton

RT. REV. MSGR. C. P. BRENNAN
Inspector of Charities for
Archdiocese
Philadelphia

MRS. EDWARD BROWNING
Member County Relief Board
Philadelphia

HON. HENRY L. CANNON
President, State Association of
County Controllers
Ebensburg

LELAND J. CULBERTSON, ESQ.
Attorney
Meadville

PATRICK FAGAN
President, Central Labor Union
Pittsburgh

SAMUEL S. FELS
President, Fels & Co.
Philadelphia

FREDERICK A. HEIM
President, The Savings Institution
Williamsport

COL. WILMER M. JACOBY
Publisher, Pittsburgh Sun-Telegraph
Pittsburgh

HON. HARRY E. KALODNER
Judge of Common Pleas Court
Philadelphia

WILLIAM R. LYNETT
Editor, Scranton Times
Scranton

MRS. T. C. MATTHEWS
President, Children's Aid Society
of Mifflin County
Lewistown

HON. JOHN H. MCCANN
Judge of Common Pleas Court
Ebensburg

JOHN A. McCARTHY, ESQ.
President, Real Estate Trust Co.
Philadelphia

AUSTIN E. McCOLLOUGH
Editor, Lancaster Intelligencer
Lancaster

JOHN A. PHILLIPS
President, State Federation of
Labor
Philadelphia

PROF. CARL J. RATZLAFF
Economist, Lafayette College
Easton

C. M. SANDWICK
Secretary, Workers' Alliance
of Pennsylvania
Bethlehem

HON. PAUL N. SCHAEFFER
Judge of Common Pleas Court
Reading

FRED FULLER SHEDD*
Editor, Evening Bulletin
Philadelphia

HON. RALPH H. SMITH
Judge of Common Pleas Court
Pittsburgh

PHILIP C. STAPLES
President, Bell Telephone Co.
of Pennsylvania
Philadelphia

REV. PIERCE E. SWOPE
St. Stephen's Reformed Church
Lebanon

ROBERT L. VANN, ESQ.
Publisher, Pittsburgh Courier
Pittsburgh

KENNETH L. M. PRAY, Secretary
Philadelphia

*Deceased

SPECIAL ADVISORY COMMITTEE

ON MEDICAL CARE

Delegated Representatives of
Healing Arts Professions and Associations

C. L. Palmer, M.D., Chairman
Pittsburgh
Medical Society of Pennsylvania

Netta Ford, R.N.
York
Pennsylvania State Nurses
Association

Charles J. Hemminger, M.D.
Somerset
Eclectic Medical Society
of Pennsylvania

H. C. Orth, D.O.
Lewistown
Pennsylvania Osteopathic
Association

Kenneth L. M. Pray, Secretary
Pennsylvania Committee on
Public Assistance and Relief

Melvin L. Sutley
Drexel Hill
Hospital Association of
Pennsylvania

R. M. Walls, D.D.S.
Bethlehem
State Dental Society

John C. Walton
Philadelphia
Pennsylvania Pharmaceutical
Association

Lena R. Waters
Philadelphia
Atlantic Division, American
Association of Medical
Social Workers

G. Harlan Wells, M.D.
Philadelphia
Homeopathic Medical
Society of Pennsylvania

Technical Staff for this Study

James F. Schell, M.D., Director of Study; Author of Report
Dorothy E. Wiesner, Assistant in Research
Edith Miller Tufts, Acting Chief of Research; Editor
Kenneth L. M. Pray, Secretary, Pennsylvania Committee on
Public Assistance and Relief

TABLE OF CONTENTS

	Page
Foreword	6
Introduction	7
Formation of Advisory Committee	7
Basic Objectives	8
Plan and Scope of Study	8
Part I--Medical Relief Prior to Federal Emergency Relief Administration	9
Poor Boards	9
Private Physicians	9
Hospitals and Clinics	10
Private Persons and Agencies	10
Part II--Emergency Medical Relief Programs (1933-1936)	10
The Beginnings	10
Federal Policy	11
Basic Rules and Principles	12
Medical Program of the State Emergency Relief Board	13
Beginnings	13
Advisory Groups	13
Basic Rules	14
Special Problems and Difficulties	14
Suspensions and Reinstatements	18
Administrative Costs	19
County Variations	19
Evaluation of Program	22
Emergency Child Health Committee	25
Part III--Other Continuing Medical Services	26
Hospitals and Clinics	26
Hospitals in Pennsylvania	26
Provision of Days of Free Care in General Hospitals	28
Out-Patient Work of the General Hospitals	29
Free out-patient Work	30
Total Dispensary Visits	30
Hospital and Clinic Distribution by Counties	30
Supplementary Data	34
State Aid to Private Hospitals	35
Nursing Facilities	36
Dental Service	38
Need for Care of Children	38
Need for Care of Adults	39
Present Dental Facilities	39
New Medical Relief Plans in Counties	40
Part IV--The Future Problem	41
Estimate of Possible Load	41
Incidence of Illness in Indigent Groups	42
Cost of Medical Care	45
Part V--Conclusions and Recommendations	47
Appendix I. Additional Tables and Charts	53
Appendix II. Montgomery County Agreement for Medical Care of the Poor	61

TABLES AND CHARTS

Text

Page

Table 1. Expenditures in Medical Relief Program by Counties to December, 1935..... 20

Table 2. Physicians' Orders Issued to Clients..... 23

Table 3. Number of Orders Issued and Their Costs Classified by Types of Health Service Provided..... 23

Table 4. Yearly Averages of Numbers of Orders Approved (Classified by Types of Service) and Amounts Paid for Orders..... 24

Table 5. Summary of Monthly Averages of Physicians' Orders..... 24

Table 6. Defects and Corrections Reported by Emergency Child Health Committee..... 27

Table 7. Dental Needs and Treatments..... 38

Table 8. Prevalence of Disabilities Among Persons on Relief, aged sixteen years and older..... 44

Table 9. Estimated Numbers and Rates of Illnesses per Year Among Persons on Relief in Pennsylvania..... 45

Table 10. Expenditures for Medical Care of Low-Income Families in California..... 46

Chart A. Kind and Extent of Disabilities in Urban Relief Population, sixteen years and older..... 43

Appendix I

Table 11. Number and Cost of Medical Orders Issued and Approved for Recipients of Unemployment Relief in 1935, by Counties..... 54

Table 12. Number and Cost of Dental Orders Issued and Approved for Recipients of Unemployment Relief in 1935, by Counties..... 55

Table 13. Number and Cost of Nursing Orders Issued and Approved for Recipients of Unemployment Relief in 1935, by Counties..... 56

Table 14. Number and Cost of Prescription Orders Issued and Approved for Recipients of Unemployment Relief in 1935, by Counties..... 57

Table 15. Total Orders Approved for Health Work for Recipients of Unemployment Relief in 1935, by Counties..... 58

Table 16. Free Hospital Service and Facilities in Pennsylvania in 1935, by Counties..... 59

Foreword

Provision of services to meet the health needs of persons receiving public assistance in Pennsylvania, or of those probably entitled to receive assistance under a revised and consolidated program, presents a most difficult and complicated problem of preliminary study, as well as of subsequent administration. It is a problem that clearly overruns the limited area of public relief alone, since it necessarily involves the policies and activities of other departments of government concerned with public health, as well as the independent services and viewpoints of many professions engaged in health service and not directly geared into public assistance machinery as such.

When the Pennsylvania Committee on Public Assistance and Relief undertook its projected study of the general relief problem, a systematic medical relief program was in operation in one branch of public assistance only, namely, unemployment relief. This program enlisted the advice and administrative cooperation of professional groups in the principal fields of the healing arts. The Committee viewed this program as a factor in its study only to the extent that it could be subjected to quantitative analysis, since, on the side of its content and quality, it was obviously a matter upon which a lay Committee could not have a decisive judgment but must largely defer to the judgment of specialized professions.

When, however, the medical relief program of the State Emergency Relief Board was abandoned in September, 1936, the Committee, which from the beginning had recognized medical care as an essential element in a complete public assistance program, was asked by the State Emergency Relief Board to sponsor a study of the need for such medical care, the facilities available for it, and the basic conditions underlying a suitable program in this field.

A Special Advisory Committee, consisting of delegated representatives of the professional groups and associations concerned with the healing arts, was created to discharge this responsibility. Its report and recommendations are presented in this booklet. The Pennsylvania Committee on Public Assistance and Relief is happy to publish this report, without subjecting it to its own examination or discussion, as a contribution to public understanding of the problem and as a possible help in the formulation of administrative policy and machinery in this important field, which is so closely related to the new public assistance program in Pennsylvania.

The Pennsylvania Committee deeply appreciates the able and earnest service of the members and the staff of the Advisory Committee in bringing to completion, in so short a time and with unanimous agreement in all of its conclusions, a study involving so many far-reaching facts and diverse interests.

Herbert F. Goodrich

MEDICAL CARE IN THE PUBLIC ASSISTANCE PROGRAM

Introduction

When, in August, 1936, the State Emergency Relief Board entered upon a period of drastic retrenchment, to meet the requirements of legislative appropriation acts which curtailed the rate of expenditure for administrative purposes, it was decided to discontinue, among other things, the entire medical relief program, which had been in operation for thirty-four months. Vigorous protests against this proposal, linked with counter suggestions for the more gradual transfer of this responsibility from the State to local groups, were registered by representatives of the healing arts professions, who had been in close touch with the medical relief program and who feared that sudden action would bring grave distress and possibly irreparable harm to many recipients of relief.*

Formation of the Advisory Committee on Medical Care

Following the definite termination of the medical relief program, which occurred on September 25, 1936, the State Emergency Relief Board accepted a suggestion, presented by representatives of the healing arts professions**, for the appointment of a committee to study the whole problem of medical care of the indigent and to recommend the basic conditions upon which a medical relief program should be established. The Board asked that this committee be associated with the Pennsylvania Committee on Public Assistance and Relief, which was engaged in a thorough study of the whole relief problem.

Accordingly, in November, 1936, a Special Advisory Committee on Medical Care, to cooperate with the Pennsylvania Committee on Public Assistance and Relief, was appointed, consisting of representatives of the healing arts professions, selected by the several professional societies which had been included in the previous program and by the Pennsylvania Hospital Association. The Secretary of the Pennsylvania Committee also became a member of the Advisory Committee. In January, 1937, James F. Schell, M. D., of Philadelphia, formerly medical advisor to the County Relief Board of Philadelphia, was appointed as full-time secretary of this committee and director of the study. Office facilities and equipment, together with supervisory, statistical and clerical assistance, were provided in the headquarters of the Pennsylvania Committee on Public Assistance and Relief.

*On August 14, 1936 representatives of the State Dental Society, Pennsylvania Pharmaceutical Association, Pennsylvania State Nurses' Association and the Medical Society of Pennsylvania, met with representatives of the Emergency Relief Board to urge reconsideration of the proposal to terminate the medical relief program. On September 19, representatives of these societies appeared before the State Emergency Relief Board and presented brief formal statements expressing the specific reasons for this position.

**On September 24, at the request of the Board, Dr. George L. Laverty, Chairman of the Medical Advisory Committee of the State Emergency Relief Board, and designated spokesman of all the professional societies of the healing arts groups, presented a proposal to the Board suggesting the continuance of the medical relief program in certain counties, pending the completion of a study of the problem by a special committee to be created for the purpose.

Basic Objectives

The Pennsylvania Committee on Public Assistance and Relief, in its first General Report, presented to Governor Earle on December 15, 1936, included the following recommendation:

> "That a program for necessary medical care should be included among the services provided to dependent persons."*

In discussing the content of an adequate relief program, the Committee also stated:

> "Necessary medical care should also be included, although expressed not necessarily in dollar values in individual budgets but in content of service supplied."**

This position was substantially in accord with that taken by the Medical Society of Pennsylvania in a resolution adopted in early September of 1936, as follows:

> "That provision for a minimal adequate sickness service to the indigent is the economic liability of society at large (the taxpayers) and is the professional responsibility of the County Medical Society, has long been the contention of the organized medical profession in Pennsylvania; and that the Board of Trustees of the Medical Society of Pennsylvania (8,250 members) immediately request Federal and State relief authorities to abandon emergency medical relief service in the counties of Pennsylvania only as and when it is justified by stabilized re-employment of all employables and humane service to the unemployables."

Plan and Scope of the Study

The plan and scope of the study undertaken cooperatively by the Special Medical Advisory Committee and the Pennsylvania Committee on Public Assistance and Relief were determined by two main objectives:

(1) To discover as quickly and fully as possible the extent of the need for medical relief in Pennsylvania and the available facilities and methods for meeting those needs. This necessarily included a study of the incidence of illness or of need of health treatment among those receiving other forms of public assistance and those on the borderline of economic dependency whose own payment for necessary health service might bring them into the relief group. It required also an analysis of available information on medical relief programs, both the recently discontinued State Emergency Medical Service for the unemployed and other experiments which had preceded or followed it.

(2) To recommend the scope and basic conditions, as well as the approximate cost, of a suitable and adequate program of medical care for these groups of persons in Pennsylvania.

The present report submits the results of these studies and presents the conclusions of the Special Advisory Committee.

*First General Report, Section 6, subsection 2, paragraph (e), page 72.
**Ibid, page 78.

Part I

Medical Relief Prior to Federal Emergency Relief Administration

Until April, 1933, medical care of the indigent was largely provided from four sources, namely, the County poor boards, professional persons in private practice, hospitals and clinics, and some private social agencies. It is difficult to determine, because of the lack of adequate records, the extent of the services thus provided. It is fairly certain, however, that altogether they fell far short of meeting the need.

Poor Boards

The administration of medical assistance to the indigent under the Poor Boards suffered from the same handicaps as other parts of poor relief. The pattern of its activities was laid down 300 years ago to deal with problems consequent upon the breaking up of feudalism in England. It was perpetuated in the law passed in 1682 in Pennsylvania by William Penn's First Assembly and in the First General Poor Law of 1705. Though several revisions have taken place in the meantime, the latest codification having been enacted in 1925, and though hundreds of special acts affecting particular districts have been passed in the meantime, the basic principles of the poor law and the basic conditions attending its administration have not been greatly changed. Its spirit may be summarized as follows:

(1) Relief of destitution is a local responsibility. It should be administered by local, elected officials and financed by local taxes (typically real estate taxes).

(2) In order to prevent the indigent from migrating and to protect communities from having to care for "outsiders", a prime consideration in granting assistance should be: Does the applicant have a legal settlement in the particular town or county where he seeks help?

(3) Poverty is something of a disgrace and is generally due to failure to make provision for a rainy day, to chronic shiftlessness, or to unwillingness to work. Therefore, assistance in any form should be limited to the barest minimum; it should be made humiliating and difficult to obtain, and the lot of a person receiving it should be so unenviable that "pauperism" will be effectively discouraged.

Medical care under the Poor Boards varied greatly from county to county. In many communities it was limited to bare emergency attention to the inmates of the poor house or almshouse. Other communities made some effort to supply attention in the home by means of county "poor doctors". These positions were frequently offered to the lowest bidder, and the pay varied from $120 to $400 a year.

Other Poor Boards had made agreements with private physicians to attend indigent patients referred to them by Directors of the Poor or County Commissioners on a reduced fee-for-service basis. This service was often restricted to grave emergency conditions and too frequently it consisted chiefly of arrangements to minister to the final needs of patients at the point of death, or to have patients admitted to a hospital.

Private Physicians

The main part of the load of medical service of those unable to pay has been carried by private professional practitioners as charity work. No records are available to show the exact size of the load carried in this manner, as these visits are rarely entered in the books of professional

persons. Most of them will take care of old patients who have recently become relief clients because of unemployment or reduced employment, and many will give free attention to total strangers if the conditions demanding it are urgent enough, but just how much other free medical service is given by individual physicians is uncertain.

Hospitals and Clinics

In localities where hospitals are conveniently located, much free medical service to the indigent is supplied in both the out-patient departments and the hospital wards. In some counties the poor directors have made financial arrangements with hospitals to take care of certain designated cases in the wards; but this remuneration is usually restricted to the care of inmates of the almshouse or of indigent persons who are well known to the poor authorities.

The actual amount of free service given to indigents by hospitals will never be known, because no standard system of records for this purpose has been adopted. It has been estimated that as high as 45 per cent of the out-patient department work in recent years has been given to relief clients.

Private Persons and Agencies

Most of the private social agencies do not attempt to supply a regular sickness service in the home. They do, however, often perform the valuable duty of seeing that such a service is provided when necessary by some existing health agency in the community. A private charitable agency may also authorize and finance temporary medical care in the home for a sick client in an emergency, until other provisions can be made or until the patient is placed in an institution.

A certain amount of individual charity is going on all the time between members of families, between neighbors, between employers and employees, and in other ways, but this coverage must, by its very nature, be spotty and inconstant and would not make much impression on the entire problem of a medical service to the indigent.

Part II

Emergency Medical Relief Programs (1933-1936)

The Beginnings

The first substantial change in the direction of more systematic and general medical care of indigent persons was made possible after the State Emergency Relief Board had been in operation a little more than a year.*

At the outset of the State relief program it was contemplated that food would constitute the only type of relief to be supplied by State and Federal funds. Other relief needs were considered at the time as being a local responsibility. Average monthly grants, including the entire allowance for the average family, statistically composed of about 3.5 persons,

*State Emergency Relief Board was created in August, 1932.

at different periods during the first year, were as follows:

September,	1932	- $ 7.23
January,	1933	- 12.93
June,	1933	- 14.52
October,	1933	- 16.29

The development of the direct relief program during this year and afterward, was marked by a continuous expansion, both in the types of direct relief provided, and in the quantities or amounts allowed for each type. The following chronological table traces this expansion:

(1) September 1932 - Food only type of direct relief granted; first allocation to the Department of Health for distribution of milk.

(2) October 1932 - First fuel relief authorized.

(3) December 1932 - First shoes distributed.

(4) March 1933 - Thrift Gardens program inaugurated.

(5) November 1933 - Clothing purchased and distributed.

(6) December 1933 - Medical Relief Program inaugurated.

(7) August 1934 - Shelter (Rent) allotment added to permissible grant.

(8) December 1934 - Public Utilities (Light and cooking fuel)

Federal Policy on Medical Relief

"The conservation and maintenance of the public health is a primary function of government."

With this opening sentence of "Rules and Regulations No. 7" issued in July, 1933, the Federal Emergency Relief Administration laid the foundation for a vast program of medical, dental, and nursing care for families receiving unemployment relief. At the time this circular was published there were 15,000,000 persons in America to whom its provisions applied, and 1,773,000 persons, or 412,569 cases, were in the State of Pennsylvania.

The majority of them, when confronted with sickness, in addition to their financial troubles, were forced either to accept its consequences without intervention, or to throw themselves upon the charity of some physician, often one whose own income was falling so rapidly that he was in little better financial condition than those he served.

The program announced by the Federal government inaugurated the far-reaching policy that medical care is a necessity, along with the other fundamental needs of the relief budget, such as food, clothing, shelter. It declared a second principle of major importance: "That the physician should be compensated for his service to the unemployed and their families; furthermore, that the traditional relation between sick person and a family physician should be maintained wherever possible; and that the State and local relief agencies should secure advice and systematic cooperation from the organized professional societies in setting up the service."

Because of the wide variation among the local facilities, standards, and needs, the new regulations permitted a liberal degree of adaptation by

each state; having established certain fundamental principles and certain minimum standards, and having outlined an administrative framework, the Federal government left each State free to experiment in the creation of a plan which might meet its peculiar need.

Basic Rules and Principles of Federal Program

The medical relief program inaugurated under "Rules and Regulations Number 7," was based upon the following specific instructions:

(1) The responsibility for authorizing care rests with the relief officials.

(2) All licensed physicians, nurses, and dentists are eligible to participate in the program upon their willingness to abide by conditions laid down.

(3) The State and local administrations are to look to advisory committees of physicians, dentists, and nurses for help in setting up the program.

(4) Rates for paying physicians, dentists, and nurses are to be worked out between the professional groups and the relief administration, on a fee-for-service basis whenever possible.

(5) Payments from Federal funds may be made for care in the home or the professional office, but may not be made for hospital service.

(6) The use of clinics, hospitals, and other existing facilities is not to be supplanted. Federal Emergency Relief funds shall not be used in lieu of local or State funds to pay for these established services.

(7) Other limitations are placed on the scope of the program, such as the restriction of the care of most acute cases, to 2 weeks or 10 visits; of chronic cases, to 3 months, with a maximum of one paid visit a week; of dental care, to emergency extractions and repairs.

(8) Only those illnesses which cause acute suffering, interfere with earning capacity, endanger life or threaten some new and preventable handicap, qualify for treatment. The common aim should be the provision of good medical service at a low cost, to the mutual benefit of indigent patient, physician, nurse, dentist, pharmacist, and taxpayer.

(9) Prescriptions are restricted to those drugs listed in the National Formulary and the U. S. Pharmacopeia.

In Pennsylvania, the medical department was set up in November, 1933, and issued its first medical orders in December, 1933. This original program was entirely financed by Federal funds.

As might be expected, during the first months of operation the medical program was variously applied and interpreted throughout the State. The big job of educating the relief visitors, clients, and physicians, nurses, dentists, and pharmacists, as to the newly established program, was slow in being realized.

Though the State Emergency Relief Board circulated Bulletin #7 (Federal Emergency Relief Administration) widely throughout the State to the doctors, dentists, and their organized societies and to the local relief boards, and though individual county medical societies published explanatory articles in their local publications and journals, the new program was very poorly understood and irregularly adopted. Some localities failed to use it at all and others immediately began to abuse it.

Medical Program of the State Emergency Relief Board

Federal relief grants to states were broadly designated for general relief purposes. Hence, it is impossible to determine at this time the exact source of all the moneys which supported the medical relief program in Pennsylvania during its 34 months of operation. It was financed throughout by a mixture of Federal and State funds which were pooled for the general purpose of relief in all of its phases, of which medical costs represented about two per cent of the total. From 1932 to 1934 the Federal grants constituted a considerable portion of the total; after 1935, Federal funds were available only for a few special types of expenditures, appropriations from that source for direct relief having been discontinued in December, 1935.

Beginnings

The State Emergency Relief Board at Harrisburg set up a Medical Department in November, 1933, with Dr. Harold Miller of Pittsburgh, as Medical Director. Dr. Miller, prior to his appointment, had been a practicing physician, specializing in obstetrics, and also had held a teaching appointment in the Department of Obstetrics at the University of Pittsburgh Medical School. He was supplied with necessary secretarial and clerical assistants to carry on the work of the department. At a lator date, districts were organized throughout the state corresponding to the State Emergency Relief Board district areas of administration. The district areas frequently employed a full time medical worker, usually a nurse or a medical social worker, to administer the program locally, in cooperation with a medical advisory committee from the local county medical societies. In the cities of Philadelphia and Pittsburgh, however, a doctor was employed on part time to direct the medical program and to cooperate with the Medical Advisory Committee. Later C. J. Hollister, D.D.S.,of Harrisburg,was appointed advisor to Dr. Miller on dental matters. The general relief organization was utilized to issue and audit all orders, certify clients and conduct investigations in each county of the state.

Advisory Groups

Many non-paid professional advisory groups were formed throughout the state to assist the State Emergency Relief Board medical department. The medical profession supplied a central advisory committee selected by the Pennsylvania Medical Society. Similar committees were set up by the nurses and dentists. The county medical societies, of which there are sixty in Pennsylvania, appointed local advisory committees to review and adjust all bills from participating physicians and attempt to settle disputes and to see that medical standards were maintained. These groups were not vested with any administrative powers; their function was entirely advisory. The State Medical Director, however, tried to follow their advice whenever possible in matters of policy and practice, but occasionally it was necessary to submit some questions to the Central Advisory Committee at Harrisburg for settlement. In questions of financial settlement occasioned by the shortage of relief funds available at any particular time, the medical director himself made the necessary adjustments to bills without the benefit of consultation with any of the advisory groups. Such bills were returned with the simple notation "adjusted according to funds available."

Basic Rules

In 1934 the State Emergency Relief Board issued a pamphlet of rules and regulations to supplement the one issued at an earlier date from the Federal Emergency Relief Administration (Bulletin #7). It outlined the new program in a more concise and detailed manner and explained the State set-up and the proper way to use the necessary forms and blanks. The general scope of the program as outlined in this pamphlet was practically identical with that set forth in Bulletin #7.

It contained a "Fee Schedule" as follows:

(1) Authorized home visit - the prevailing minimum fee, but not to exceed $2.00;

(2) Authorized office visit - the prevailing minimum fee, but not to exceed $1.00;

(3) Authorized obstetrical care in the home as outlined (6 prenatal visits; the delivery; 3 post-natal visits) not to exceed $20.00 in the aggregate.

(4) Accessory Services--

A. Authorized bedside nursing visit not to exceed 85¢ each. Authorization for bedside nursing care for acute illness shall be limited to not more than 10 visits - a maximum expenditure of $8.50. In chronic illness the maximum shall be 6 visits ($5.10), the purpose of which shall be demonstration and instruction to some member of the household, in addition to giving the care.

B. Authorized emergency dental extractions and repairs (to include cost of anesthesia) not more than $1.00 for the first tooth nor more than 50¢ for each additional tooth, provided the maximum charge for a given patient shall not exceed $10.00.

C. Authorized prescriptions must not exceed 50¢ in cost and all those costing more than 25¢ must have the formula copied on the face of the blank. Note: No statement as to the number of prescriptions which could be issued to a family was made in this pamphlet.

Separate forms for authorization of medical, nursing and pharmaceutical orders were prescribed.

While it would seem that the participating persons were made fairly well acquainted with the scope and limitations of the program, there still existed a great deal of confusion in their minds.

Special problems and difficulties

Among other sources of difficulty and confusion were the following:

1. The interpretation of what constituted a minimum adequate service in any particular case, and the adjustment of bills.

Bills were not adjusted on a straight fee-for-service basis, but according to standards of "minimum adequate service." For example: one doctor considered six visits necessary in a particular case of uncomplicated grippe and

accordingly submitted his bill for 6 visits at $2.00. It was discovered that most doctors were able to cure similar cases of grippe with an average of 3 visits, so the doctor's bill was reduced from $12.00 to $6.00 and returned to him with the notation that the program provided only minimal care, which in this case amounted to 3 visits. He was then requested to accept this reduction gracefully and rebill the case at the recommended figure. Thus the doctors were actually paid according to a fee schedule based on the diagnosis and not on a fee for service basis as set forth in the pamphlet of instructions.

This shift to the fee schedule principle was made without changing the written rules or explaining the change fully to the participating professions.

This difficulty was encountered mostly by the physicians. The dentists felt it to a lesser degree, because their type of work lends itself more readily to the modified fee-for-service principle. The nurses' bills were not adjusted except to maximum service allowed, and the pharmacists' charges were only adjusted according to the pre-determined maximum price of the individual prescription and not according to the number of proscriptions filled.

2. The rigid limitations of the program caused a considerable amount of dissatisfaction on the part of the doctors, dentists, nurses, pharmacists, relief clients, and relief officials alike. Patients really had to get sick and well according to preconceived expectations in order to keep the program running smoothly.

Medical orders were issued on a family basis and not to individual patients. The doctor was expected to supply the necessary medical attention to the family, regardless of the number of sick persons it contained. The medical order automatically expired at the end of two weeks whether the persons had recovered or not. For example: Suppose the original order was issued for Mr. J. D., Sr., who was suffering with La Grippe. In this family there were also four children and his wife, who were apparently well at the time the original order was issued, but became ill, one after the other, at three-day intervals. At the expiration of the two weeks, 3 patients had recovered, 3 others were sick, with the prospect of at least another week of illness in the group, not taking into account the possibilities of complications developing. It was necessary for the doctor to visit the family at a minimum of every other day, or seven times in two weeks. He might have found it necessary to go more than once in any one day, if one child, contrary to rule, became sick at 10 P.M. with a very high temperature and a convulsion. (Note: According to the rules of billing, not more than one visit a day will be paid for). At the end of two weeks, the original medical order expired and could not be renewed for the same complaint, and the doctor was expected to carry the family along, as charity, until they were all well again, even if their illness extended for another month.

The doctor then made up his bill showing that he treated 6 persons for La Grippe, giving their names and ages, and listing 7 visits and 1 night call, making a total of $16.00. More than likely, this amount would be reduced, either by the Medical Advisory Committee or by the Harrisburg office, to about $8.00 or $10.00 maximum. The doctor might be dissatisfied and might hesitate to cooperate in the future with a program which is too inelastic to adapt itself to conditions which actually exist.

Another difficulty along this line was with acute and chronic cases. When medical care was authorized for a chronic case, for a definite number of contacts over a period of 8 weeks, that case immediately became inflexible. As is well known, a patient suffering from a chronic disease is liable to an acute flare-up of this complaint or may be stricken with some other ailment

at any time. The Medical Relief Program would not permit an acute order to be issued to a family which had a chronic order in operation. This ruling said, in effect, that a chronically ill person should not have an acute flare-up of his condition, nor become acutely ill from any other cause while a chronic authorization medical order was in force. Neither should any person in that family get sick during this time. If, however, the family went ahead and got sick in spite of the rule, then the attending physician was expected to take care of them without remuneration.

Other troublesome rules of operation were:

A. Post-operative cases were to be followed along without compensation by the hospital, especially for dressings. Later on in the program some chronic authorizations were secured for these patients.

B. Diabetes, peptic ulcer and P.P. Anemia cases were to be certified by some supporting laboratory or x-ray confirmation before they could be authorized for chronic care. No financial provision was made for these special services.

C. Obstetrical cases were required to have 6 prenatal and 3 post-natal visits in order to be complete. If the patient failed to keep her pro-natal appointments, the bill was adjusted to the doctor's disadvantage. Furthermore, an inducement was offered to the doctor to try to deliver a questionably difficult case at home, rather than take her to a hospital, because he would not be paid for a delivery in a hospital.

D. Pelvic inflammatory diseases in the female could not be treated under the program, as they were venereal. Acute pelvic inflammatory disease in the female is today treated by continuous rest in bed, with ice bags and medicine to relieve the pain until all of the acute symptoms subside, after which an operative procedure is usually necessary. This period of rest in bed varies from several days to several weeks, during which time the family doctor is the ideal person to attend the patient. Hospitals hesitate to tie up their active ward beds for this length of time with such cases, which can be taken care of almost as well at home. As a result, many of these cases were refused admission to the hospital, and the doctor knew that if he sent in a medical order with the correct diagnosis he would be limited to one diagnostic visit. Consequently, many of these cases had to be carried by the physician as charity, and some cases, it is believed, were neglected.

3. The amount of clerical work necessary to make the program operate was another feature which was irritating to the doctors, dentists and pharmacists.

The rules stated that "a medical order must be used within 48 hours of date of issue;" "a medical order expires in two weeks;" "bills must be presented in duplicate not later than thirty days after the last compensable visit;" minute "clerical details must be correctly filled in on the face of the original medical order, and the same signed by both the patient (or a member of the patient's family) and the doctor." All of these details led to difficulties between the relief board and the professional people who participated. Very often a bill would be returned to a doctor two or three times before it would be finally ready to forward to Harrisburg for payment.

For example, a physician might apply in writing for a chronic authorization for a case of diabetes and, in reply, would receive a standard form to be filled out and returned. He was then authorized to make four house visits in two months. Within 30 days of his last compensable visit, he must submit his bill (on his own bill heads) in duplicate, along with the medical order properly filled in and signed. When the bill was reviewed at the

County Relief Board office, it might be found to contain several mistakes (for example, one of the signatures is missing; or the first name or age of the patient, or his condition on discharge is missing, or perhaps two visits have been listed within 7 days). At any rate, the bill must be returned to the doctor for correction. If this happened to be one case on a bill containing several other cases, then the whole lot would go back to the doctor, especially if there was any change in the amount of money billed.

These points may seem unimportant and inexcusable to clerically minded people, but for professional men, who are notoriously lax in such matters, many of whom have only kept legible records since the passage of the Federal Income Tax Law, the necessary paper work and correspondence involved in the program was a real hardship.

4. The slowness of payment was objectionable to all of the professional groups. Usually 2½ to 3 months elapsed between the rendering of a service and the payment for the service in uncomplicated cases which went through without a hitch. For example, a typical procedure on a medical order is as follows:

January 1, medical order issued; January 14, medical order expired; February 14, last day for billing; February 28, bill forwarded to the central State Emergency Relief Board office at Harrisburg, after approval by County Relief Board and medical advisory committee; March 30 to April 30, bill is paid, after 30 to 60 days required to pass through the State Emergency Relief Board medical office, to be reviewed and tabulated; through the general relief board organization for the necessary auditing and checking, and then to the State Treasurer for payment.

Another difficulty in the payment of bills was lack of information as to the cases for which a specific payment was made. If either a doctor, dentist, druggist or nursing organization happened to have a number of bills going through for payment at the same time, and a check was received from the State Emergency Relief Board, which did not cover the entire amount, there was no way to tell whether payment was being made for only part of the cases; whether the bills had been reduced at Harrisburg, or whether a mistake had been made in the amount of the payment.

In August, 1935, the State Emergency Relief Board issued another pamphlet of "rules and regulations". This outlined the program more definitely than any of the previous official publications. It did not add any new features to the program but merely tried to explain more clearly the scope of participation and rules of operation.

This pamphlet also contained a definite statement as to the basis of bill adjustments as follows:

> "All bills are subject to the economic limits of available funds, the designated average per medical order, and a total compensation in any one month. This definite control of minor ailments and accidents will enable the county medical advisory committees to authorize a reasonable extension of treatment in the more serious conditions which entail responsibility extending beyond the two weeks period, notably, typhoid fever, certain fractures, etc. Experience indicates that a fair average charge is $5.00 per medical order in urban, and $7.00 in rural communities. A limit of $100 to any participant in any one month may be applied by the local advisory committee, or by

the Administration, to conserve funds, and bring about a distribution of the work, or correct overcharges."

Suspensions and Reinstatements

The State Emergency Relief Board reserved the right to remove any professional person from participating in the medical program for irregularities or non-compliance with the rules and regulations. The exact technique of suspension procedures was not well standardized and varied from place to place. Most physicians were given an opportunity to explain discrepancies before their local county medical committee before official action was taken. A physician thus suspended could be reinstated at some later date, if circumstances warranted such action.

According to the official records of the State Emergency Relief Board the following actions of this kind were taken:

Physicians	181 physicians suspended, of which 70 were later reinstated, and 109 cases pending at the close of the program.
Dentists	164 dentists suspended, of which 18 were lator reinstated, and 144 cases pending at closing of program.
Nurses	3 nurses suspended, of which 1 was later reinstated, and 2 cases pending at close of program.
Druggists	6 druggists suspended, of which 1 was later reinstated, and 5 cases pending.
Osteopaths	6 osteopaths suspended, of which 1 was later reinstated, and 5 cases pending.
Chiropractors	2 chiropractors suspended, which cases were still pending at close of program.
Opticians	6 opticians suspended, of which 3 were reinstated, and 3 cases were pending at close of program.
Summary	14 counties had no removals. 29 counties had no dentists removed. 21 counties had no physicians removed. 65 counties had no nurses removed. 60 counties had no pharmacists removed. 65 counties had no chiropractors removed. 54 counties had no osteopaths removed. 62 counties had no opticians removed.

Administrative Costs

The medical program continued to operate until the summer of 1936. The administrative overhoad expense of the medical program was proportionately high and as the legislature definitely fixed the per cent of the total relief fund which could be spent for administrative overhead, the question of discontinuing the medical program, with its thousands of orders and investigative and auditing services, was soon considered.

It is impossible to determine accurately the entire cost of operation, because the work was so divided between different departments and groups. The State Emergency Relief Board's existing organization was utilized for certifying clients; issuing orders; most investigative procedures; auditing bills and invoices; and filing and storing invoices and bills.

The Auditor General's Department of the State of Pennsylvania also participated to some extent in the auditing of invoices. The State Troasury Department wrote and mailed checks. The Medical Advisory Committees throughout the State gratuitously reviewed bills; adjusted bills; heard complaints, conducted investigations and settled disputes; interpreted and publicised the program to the doctors; corresponded with the medical department in Harrisburg over points of principle and practice, suspensions, reinstatements and billing.

The definite administrative items which were eliminated by the closing of the program were the printing of forms; postage; administrative personnel in Harrisburg office; administrative personnel in Philadelphia and Pittsburgh areas; a full time medical worker in 24 other areas.

The regular set-up of the State and relief departments had absorbed part of the work, at some additional expense. It is impossible to determine this fraction of the operative expense exactly.

The figures for administrative overhead given at the end of Table 3, following, were calculated by the Statistical Department of the State Emergency Relief Board. The amounts listed were arrived at by taking the definitely assigned items (medical personnel, printing, postage, et cetera) plus an estimate of cost of handling the medical program in the other State and local relief departments. The final figure is thus partly estimated.

The average administrative cost per month, based on 20 months, was $28,623.78. According to this figure the cost of the medical program was 13.6 per cent of the total medical expenditure, and 1 per cent of all administrative cost of the general relief program.

County Variations

As shown in Table I, page 20, there was wide variation in the relative use and cost of the State's medical program among the counties of the State. Some of the conditions which unquestionably were factors in these county variations were:

I. The local health habits and standards of a community and their relative use of home remedies, neighborly advice, or professional service;

II. The existence of health agencies, already set up and in operation in a community (e.g. hospitals and clinics, visiting nurse associations, oral hygiene clinics, et cetera);

III. The attitude of the local relief authorities towards a medical program and the onthusiasm with which it was presented to their clients;

IV. The attitude of the local professional groups towards the program and the enthusiasm with which it was publicised and accepted by them;

V. The goneral condition of living in the various communities, affecting illness rates;

VI. The presence or absence of epidemics or catastrophic conditions in particular areas;

VII. The physical characteristics and topography of the area and the ease with which a patient can reach a doctor, and vice versa.

Every community had its own peculiar problem of administration. For instance, it is the customary practice in Philadelphia County for poor patients to patronize out-patient departments of hospitals for medical diagnosis and treatment. During the year 1935 (See Table 16, Appendix) there were 1,155.4 visits to clinios for every 1,000 persons, and only 803.4 free days of hospital care por 1,000 persons. In Allegheny County (Pittsburgh) the reverse practice is in vogue. During the year 1935 (see Table 16, Appendix) there were 1,316.8 free days of hospital care per 1,000 persons and only 321 clinic visits per 1,000.

This tondency is again illustrated in Table I. Allegheny County had 22.9 per cent of the relief load and received 19.1 per cont of medical expenditures, whereas Philadelphia County had 32.7 per cent of the rolief load but received only 9.6 per cent of medical expenditures. This difference is largely due to the fact that so many relief clients were required to continue to go to hospital clinics in Philadelphia under the rules of the program, since they already had contacts established.

In some areas in the State, the facilities for nursing, hospital and clinic care, and retail drug store service are fow and far between. In such places a medical program would operato far differently than in localities where these services are more easily available.*

Table I

Expendituros in Medical Relief Program by Counties to December, 1935*

County	Per cent of case load to State total	Per cont of Medical expenditures to State total
Adams	0.1	0.2
Allegheny	22.9	19.1
Armstrong	0.6	0.01
Beaver	1.0	1.3
Bedford	0.2	0.1

*See sections on Hospitals (page 26) and Nursing Faoilities (page 36) for further information on these points.

Table I (continued)

Expenditures in Medical Relief Program
by Counties to December, 1935*

County	Per cent of case load to State total	Per cent of Medical expenditures to State total
Berks	1.5	1.6
Blair	1.0	1.5
Bradford	0.1	0.4
Bucks	0.4	0.1
Butler	0.4	0.6
Cambria	1.6	2.2
Cameron	0.1	0.01
Carbon	0.4	0.8
Centre	0.3	0.7
Chester	0.4	1.7
Clarion	0.2	0.5
Clearfield	1.4	2.1
Clinton	0.3	2.3
Columbia	0.3	1.9
Crawford	0.6	0.6
Cumberland	0.2	0.9
Dauphin	1.1	0.1
Delaware	1.1	1.0
Elk	0.1	0.9
Erie	1.9	1.0
Fayette	2.2	7.9
Forest	0.1	0.1
Franklin	0.3	0.3
Fulton	0.1	0.1
Greene	0.2	0.5
Huntingdon	0.2	0.7
Indiana	0.8	1.0
Jefferson	0.4	0.6
Juniata	0.1	0.01
Lackawanna	3.9	3.9
Lancaster	1.0	0.9
Lawrence	0.8	0.8
Lebanon	0.2	0.01
Lehigh	1.7	1.3
Luzerne	3.8	9.0
Lycoming	0.6	1.9
McKean	0.2	0.3
Mercer	0.6	1.7
Mifflin	0.2	0.5
Monroe	0.2	0.3
Montgomery	0.6	0.7
Montour	0.1	0.2
Northampton	1.2	1.1

Table I (continued)

Expenditures in Medical Relief Program
by Counties to December, 1935*

County	Per cent of case load to State total	Per cent of Medical expenditures to State total
Northumberland	1.3	2.3
Perry	0.1	0.3
Philadelphia	32.7	9.6
Pike	0.1	0.1
Potter	0.1	0.001
Schuylkill	1.4	2.3
Snyder	0.1	0.3
Somerset	0.7	2.7
Sullivan	0.1	0.1
Susquehanna	0.4	0.5
Tioga	0.1	0.3
Union	0.1	0.2
Venango	0.6	0.6
Warren	0.1	0.1
Washington	1.2	1.5
Wayne	0.2	0.1
Westmoreland	2.1	2.2
Wyoming	0.1	0.4
York	0.8	1.0
TOTAL	100.0	100.0

Evaluation of Program

After reading the preceding material, one might get the impression that the State Emergency Relief Board medical program contained nothing but defects and limitations which prevented it from accomplishing anything useful. This is a misconception, because the program presented a bold and drastic change in the medical care of the indigent which is without precedent in this country. During the thirty-four months of its operation in Pennsylvania, not only did the indigent sick receive more medical treatment than ever before, but the economic burden of providing it was spread more widely over the general population (the taxpayers) instead of being concentrated on the shoulders of the healing arts professions where it had always been, to a large extent, in the past. If the program during its short life accomplished nothing more than the establishment of this principle, it can be said to have been highly successful.

In addition to this the program recognized the fact that health service is a basic necessity of life and placed the need for medical attention to the indigent sick in the same category as other necessities of life, such as food, shelter, clothing, etc. It resulted in a definite attempt not only to continue this service, but to improve it and set a better and more lasting organization to carry on the work which was so hastily started to meet a national emergency.

*Source of data: Commonwealth of Pennsylvania, State Emergency Relief Board, Harrisburg, Pennsylvania.

Most of the adverse criticisms which have been raised against the medical relief program attack it from the point of view of its inadequacy. It is true that it did have many limitations and did lack standardized procedures for securing consultation, laboratory, x-ray and other special necessary diagnostic and treatment services, including hospital care, but it must be constantly borne in mind that the program was set up as an emergency measure, a stop-gap plan, to supply certain specific needs which were not being adequately met by the existing agencies. It was not conceived or considered as a "complete health service" program.

In the course of the program the social workers discovered the varied and often complicated difficulties of the physician, and the medical profession learned something of the social problem as a whole and the problems of the social worker in particular. In working together on their common problem of making funds go as far as possible in aiding the needy sick, all the professions concerned have profited by the contact.

Table 2

Medical Relief Program of State Emergency Relief Board (1933-1935)

Physicians' Orders Issued to Clients

By year of program	Average number of cases on relief	Physicians' orders issued to SERB clients	Physicians' orders issued per 1,000 cases on relief
34 months' total	317,919	755,238	2,375.6
12 months of 1934	339,344	282,145	831.4
12 months of 1935	414,158	368,984	890.9
10 months of 1936	176,723	104,109	589.1
Average per month	317,919	22,213	69.9

Table 3

Number of Orders Approved and Their Costs Classified by Types of Health Services Provided for Relief Clients

Services in Program	Number of Orders Approved	Amounts Paid for Orders and Administration	Average Amount Paid per Order
Total	1,931,700	$6,385,291.70	$3.31
Physicians' orders	777,140*	4,338,825.44	5.58
Dentists' orders	235,243	855,143.24	3.64
Nurses' orders	29,898	181,747.33	6.08
Prescriptions	889,419	437,099.99	0.49
Administration Estimated	-	572,475.70	-

*These include some orders to persons on work relief.

Table 4

Yearly Averages of Numbers of Orders Approved and Amounts Paid for These Orders

Items	Physicians	Dentists	Nurses	Prescriptions
Total number of orders approved in 34 months	777,140*	235,243	29,898	889,419
Average number of orders in 12 months	274,285	83,027	10,552	313,913
Average number of orders in 12 months per 1,000 cases	862.8	261.2	33.2	987.4
Total amount paid for orders in 34 months	$4,338,825.44	$855,143.24	$181,747.33	$437,099.99
Average amount paid for orders in 12 months	$1,531,350.16	301,815.26	64,146.12	154,270.58

Table 5

Summary of Monthly Averages of Physicians' Orders

Average cases receiving State Emergency Relief Board direct assistance during the 34 months of the medical program.....	317,919
Average number of persons per case.....	3.7
Average number of persons per month.....	1,176,300
Average number of physicians' orders approved per month.....	22,857
Average number of persons served per physician's order.....	1.5
Average number of persons served per month by physicians' orders.....	34,286
Number of persons served per month per 1,000 persons receiving State Emergency Relief Board relief.....	29.1
Average monthly expenditure for physicians' orders.....	$127,612.51
Average monthly expenditure for physicians' orders per case on relief.....	$0.40
Average monthly expenditure for physicians' orders per person on relief.....	$0.11
Average monthly expenditure for total medical care** program, including administration	$187,802.70

* Some of these orders were issued to persons on work relief.
**Including physicians', dentists', nurses' and pharmacists' services.

The Emergency Child Health Committee

Organization and Function. Another agency which was created during the days of the depression was the Emergency Child Health Committee. At the request of the Governor, in 1933, this committee, of which the Governor is Honorary Chairman, was organized throughout the state by the Medical Society of the State of Pennsylvania, with Dr. Samuel McC. Hamill as Chairman. The organization consisted of a central or state committee, having representation from every publicly and privately supported agency directly or indirectly interested in the health of children. The membership of this committee was chosen on a non-political basis. County committees were organized by the County Medical Societies. Groups have not yet been organized in every county, due to local difficulties, but steps towards organization were taken and approved in 58 counties.

The purpose of the Emergency Child Health Committee, which is continuing, is to supervise the health needs of children of families on relief and, to some extent, of children of families in the very low income groups who were just above the relief level.

Groups of interested physicians have been organized in the various counties, in some instances amounting to 100% of the membership of the County Medical Society, to examine the children and record all defects on standard examination forms which are supplied by the State committee. These physicians give their time gratuitously, and up to March 1, 1937, 121,914 children had been examined and 346,469 physical defects discovered.

Corrective Services. In order to avoid duplication of effort and interference with the activities of already existing agencies, the Emergency Child Health Committee secured the cooperation of these health agencies in making the necessary corrections, leaving the Committee responsible only for the correction of defects of children not under other supervision. Up to March 1, 1937, 138,714 corrections were made and 5,202 diagnostic procedures carried out. (See Table 6 following)

In the correction of dental defects, the county committees have had invaluable cooperation from the dental profession, who are giving liberally of their service and have in many instances provided necessary materials.

An important phase of the work is the nutrition instruction given to 55,600 mothers. This instruction is limited to budgeting the weekly food money to twenty-one well-balanced meals, the purchasing of low-cost foods of high nutritional value, and the palatable preparation of these cheap foods.

The reproduced table supplied by Dr. S. Mc C Hamill will illustrate the scope and magnitude of this work. (Page 27)

Financial Support. The expenses of the central or State Emergency Child Health Committee were met by grants secured through the State Emergency Relief Board, at first from the Reconstruction Finance Corporation and later from the Federal Emergency Relief Administration. In 1936, the State Emergency Relief Board was unable to continue full financial assistance, due to lack of funds, and a grant was secured from the American Child Health Association in Liquidation, to help out. In addition, some nurses and clerical workers were secured to assist the county committees through the Civil Works Administration, who were later transferred to the Work Division of the State Emergency Relief Board and finally to the Works Progress Administration.

General Results. Aside from the number of examinations made and defects corrected, the Emergency Child Health Committee believes it has accomplished a great deal as an educational program:

1. It has broadened the interest of many physicians in making complete health examinations of children, using a standardized method of procedure and of recording;

2. It has broken down many of the barriers between the medical profession and existing health agencies, for under this program they are all working together under medical leadership;

3. It has been of great educational value to the young lay workers who have assisted the physicians in carrying on the work (to be present at the examinations and to learn the great number of defects found in presumably normal children was a valuable experience to these young mothers and potential mothers);

4. The results of this work may constitute a basis of appeal to families of higher income, to secure periodic health examinations for their families.

Even though the Committee's work was set up as an emergency measure, it is the hope of those associated with it that it can be carried on permanently in a somewhat modified form when the emergency ceases.

Part III

Other Continuing Medical Services

Along with these emergency measures, bringing professional service at public expense for the first time on a State-wide scale to the aid of disadvantaged citizens of the State, other long-established services such as hospitals and out-patient clinics and dispensaries, were subjected to increased pressure during the depression. Still others, such as those of nursing and dental treatment, were expanded to meet new demands, though without being so definitely and universally placed at the disposal of relief clients.

Hospitals and Clinics

As before remarked, a considerable portion of the load of medical care of those unable to pay for treatment has been borne through the depression, as long before, by hospitals, both in their wards and in out-patient departments. No exact and complete record of their service to these patients is available, but certain partial records have been utilized as a basis of rough estimations of the part these agencies have played in the past in the total program of medical care of indigent persons, and as an indication of the place they might take in a more nearly adequate program in the future.

Hospitals in Pennsylvania

According to the Directory of the American Medical Association for 1936, there are 362 hospitals in Pennsylvania, of which 236 may be described as general hospitals and 126 as special hospitals. Among the latter are institutions for children; for convalescents; for drug and alcoholic patients; for care of eye, ear, nose, and throat conditions; for aged persons; for the incurable; for contagious diseases; for maternity; for mental and nervous patients; for orthopedic treatments; for rest cure; for skin and cancer diseases; for tuberculosis; and for venereal diseases. Others are in prisons

Table 6
Defects and Corrections Reported by Emergency Child Health Committee - To March 1, 1937

	Defects Found			Preventive Measures; Defects Corrected; or Patients under Treatment		
	No. of exams on which % is figured*	No. of defects	Per cent	No. of defects on which % is figured****	Number Corrected	Per cent
TOTAL	121,914	346,469	-	-	138,714	40.0##
Miscellaneous Defects	-	17,743	-	-	14,532	-
Not Vaccinated	118,018	41,576**	35.2	37,591	17,098	45.5
Not Having Had T.A.T. or Toxoid	118,018	74,948***	63.6	70,417	33,223	47.2
With Eye Defects	118,018	8,754	7.4	8,478	3,785	44.6
With Ear Defects	118,018	3,657	3.1	3,478	1,294	37.2
With Nasal Obstructions	118,018	9,495	8.1	9,397	5,532	58.9
With Diseased Tonsils	118,018	41,990	35.6	39,225	13,290	33.9
With Dental Caries	118,018	49,311	42.2	47,745	15,570	32.7
With Enlarged Cervical Glands	117,945	24,446	20.7	20,992	4,466	21.3
With Thyroid Gland Enlargement	117,945	2,965	2.5	2,774	879	31.7
With Lung Affections	117,945	2,755	2.3	2,643	1,135	42.9
With Cardiac Defects	117,945	2,819	2.3	2,542	867	34.1
Needing Circumcision	117,945	7,169	6.1	6,964	1,075	15.4
With Venereal Diseases	117,945	426	0.4	426	289	67.8
With Malnutrition	117,945	31,268#	26.5	29,721	18,720	63.0
With Postural or Orthopedic Defects	117,945	8,126	6.9	7,389	2,515	31.9
With Deficiency Diseases	117,945	7,499	6.4	7,165	3,281	45.8
With Behavior Disorders	110,128	11,112	10.1	10,033	1,163	11.6

* In each case the percentage is figured on a different total of examinations because of the difficulty of securing complete and consistent reports from the counties.

** Of this number, 37,816 occurred in children under six years of age - 74.4%.

*** Of this number, 37,184 occurred in children under six years of age - 73.2%.

\# Of this number, 11,564 occurred in children under six years of age - 22.7%.

**** These totals do not include the defects reported by counties which are known to be securing corrections but which have not reported such corrections. They do include the defects found in counties so recently organized that the correction of defects has not yet been started.

Calculated on basis of known defects for which opportunity has been given for correction-307,480-this percentage becomes 40.4.

Additional Services - Nutrition Instruction to Mothers - 55,600 in 45 counties.

Immunization in 10 counties-11,018 (Bradford, Carbon, Elk, Indiana, Lackawanna, Luzerne, Montour, Perry, Somerset and Washington).

Diagnostic Procedures, 5,202. Re-examinations, 6,717.

and reformatories, in schools, and similar institutions.

Of the 236 general hospitals, 212 or 89.8 per cent were non-official hospitals, that is, institutions controlled by non-profit associations, by church and fraternal organizations, or by individuals and partnerships. The other 24 were governmental, or official hospitals, that is, were supported entirely by tax funds, city, county, State, or Federal.

Of the 126 special hospitals, 82 or 65.1 per cent were non-official hospitals. Of the total 362 hospitals in Pennsylvania, 294 or 81.2 per cent were operated by non-official organizations.

Of these 362 hospitals, 187 or about 50 per cent of all, were smaller hospitals with less than 100 beds (including bassinets). Only 37 were listed as having 500 beds or more; the remaining number, 138, were medium sized hospitals, from 100 to 499 beds. There were 19 hospitals of more than 1,000 beds, 17 of which were special hospitals, all caring for mental diseases. These facts are shown in detail in Table 16 at the end of this study.

Provision of Days of Free Care in General Hospitals

The number of days of free care* in hospitals supported by non-profit associations, by church and fraternal organizations, and by official sources, have been tabulated from official reports, from a questionnaire distributed by this Committee, and from reports of a survey by the Pennsylvania Hospital Association, covering, so nearly as possible, the year 1935. It is not possible, however, to learn the relief status of the persons receiving free care.

There were 206 of these general hospitals.** Of these 206, 182, or 88.3 per cent, were non-official hospitals. Only 9 of the 182 non-official hospitals had more than 500 beds. Of the 24 official general hospitals, 5 had more than 500 beds.

Of the 206 general hospitals, data on number of days of free care were available for 160, and from these facts satisfactory estimates were prepared for the other 46. In these general hospitals, including both official and non-official hospitals, 5,734,462 days of free care were supplied. The 182 non-official general hospitals supplied 2,688,455 of these days and the 24 official hospitals supplied 3,046,007 days. If the July 1, 1935, population of Pennsylvania is estimated to be 10,066,000, there were 569.7 days of free care per thousand of population in the twelve-month period.

*The days of care given to full-pay patients in the questionnaire of the Hospital Association of Pennsylvania included the new-born, and were termed "full-pay" regardless of whether the full amount of the bill was collected or not. The days of care given to part-pay patients (including the new-born) were so termed whether the part charged to the patients was collected or not. Thus, the number of days of care given to free patients are not actual days of free care, but days of care given to patients who came into the hospital to receive free care.

**This figure of 206 omits 30 institutions which were proprietary hospitals, (called "all others" on Table 16), proprietary hospitals being those controlled by individuals or partnerships, and presumably providing little or no free care.

From the same data it is possible to calculate the per cent of days of free care for 160 of the 206 institutions. Of these the greatest number of institutions in any one group, 37 of the 206, supplied between 30 and 39 per cent of all their hospital days free of charge. There were 24 hospitals which supplied 20 to 29 per cent of their days free of charge. Only 13 hospitals supplied less than 20 per cent of free days. There were 32 hospitals that supplied 40 to 49 per cent of days free of charge to the patient, 28 that supplied 50 to 59 per cent, 10 that supplied 60 to 69 per cent and 16 whose per cent of days of free care was over 70. Thus, in about one-half of the hospitals giving general, surgical, and medical care, 40 per cent or more of the days of care were given free. These figures are somewhat affected by the fact that a greater per cent of non-official hospitals returned questionnaires than official hospitals, and the larger non-official general hospitals returned a greater per cent of replies than the smaller hospitals.

These reports indicate that the larger the hospital the higher the per cent of days of free care. This has important bearing on the problem of hospital care for indigent patients, since it would seem that in districts where there are large general hospitals there is greater chance of getting free care. In 17 counties in Pennsylvania there are either no hospitals or only small hospitals of less than 50 beds. In these counties the provision of adequate free hospital care within the county is manifestly difficult, and patients must often be taken to the larger hospitals in more distant cities.

Out-Patient Work of the General Hospitals

Of the 182 non-official general hospitals, 140 or 76.9 per cent have out-patient departments, according to the 1936 American Medical Association Directory. Of the 24 official general hospitals, 19, or 79.1 per cent, have out-patient departments. It appears that the larger the hospital, the more apt it is to have an out-patient service. However, only 118, or 64.8 per cent, of the non-official hospitals and only 6, or 25.0 per cent, of the official hospitals returned out-patient data on their questionnaires.

The number of visits made to out-patient departments in the 1935 twelve-month period was available for 131 of these 206 general hospitals, 121 of which were non-official and 10 official.

Of the 39 non-official hospitals with less than 100 beds, for whom out-patient data were available, 20 reported having had less than 1,000 visits in the twelve-month period; 12 reported from 1,000 to 5,000, and 7 reported more than 5,000 visits, the greatest number of visits to any one of these small hospitals being 23,600. Of the 73 non-official hospitals having from 100 to 500 beds, which provided out-patient data, 3 reported having had less than 1,000 visits; 12 reported from 1,000 to 5,000; 50 reported from 5,000 to 50,000 visits a year; and 8 reported more than 50,000 visits a year. Of the 9 hospitals with more than 500 beds, which provided out-patient data, none reported less than 10,000 visits, and 5 reported more than 100,000 visits in the twelve-month period.

Out-patient department data were less complete for the official general hospitals, only 10 of the 24 supplying these facts. Of the 10 official general hospitals for which out-patient data were available, 2 reported less than 5,000 visits; 5 reported from 5,000 to 10,000 visits; one reported from 10,000 to 20,000 visits; one reported from 30,000 to 40,000 visits; and one reported more than 100,000 visits. Table 16 in Appendix I shows this material in more detail.

Free out-patient Work

The cost of out-patient service is very difficult to ascertain. The Pennsylvania Hospital Association questionnaire asked for the total receipts from out-patients for services in the clinics, and for the total cost to the hospital of their out-patient work. The per cent of free work was calculated for this study by subtracting the receipts from the cost and dividing the remainder by the total cost figure.

The material as sent in by the 100 non-official hospitals which attempted to answer these questions varies so broadly that it may be of little value. There were 16 hospitals whose out-patient work seemed to pay for itself, since the receipts from patients were equal to or above the cost to the hospital as reported. None of those 16 had more than 20,000 visits in the twelve-month period. There were 4 in which less than 25 per cent of their work seemed to be free service; 12 in which 25 to 50 per cent seemed to be free; 26 in which 50 to 75 per cent seemed to be free; and 42 hospitals in which 75 per cent or more of their out-patient work seemed to be free. As might be expected, the hospitals with large out-patient services were more likely to have cost information and were more likely to show a higher per cent of free work. Among the 46 reporting hospitals having less than 10,000 visits in a year, 16, or 34.8 per cent, stated that 75 per cent or more of their out-patient work was free to the patients. Of the 42 reporting hospitals having 10,000 to 50,000 visits per year in their out-patient departments, 18, or 42.9 per cent, stated that 75 per cent or more of their out-patient work was free to the patients. Of the 12 reporting hospitals having more than 50,000 visits a year to their out-patient departments, 8, or 66.7 per cent, stated that 75 per cent or more of their out-patient work was free to the patients. Among the 24 official hospitals, data about out-patient work were too meager to show any facts about costs.

Total Dispensary Visits

Patients made 2,992,778 visits to the out-patient departments of non-official hospitals in the twelve-month period. If the available reports provide a reliable basis for an estimate, only 445,840 visits were made to the out-patient departments of official hospitals, and more than 300,000 of these were made to three large hospitals. The total number of visits to out-patient departments of general hospitals in Pennsylvania, official and non-official, in the twelve-month period, was 3,438,618.

If it may be assumed that clinics are open during 300 days of the year, then each day, on the average, 11,462 persons in Pennsylvania are visiting out-patient departments of general hospitals. If the 1935 Pennsylvania population estimate of 10,066,000 persons is accepted, the number of clinic visits per thousand population in twelve months is 341.6. The population of Pennsylvania is about one-third rural, and includes many areas in which there are no hospitals for many miles. It is also true that in the more largely rural districts the general hospitals are smaller and are less likely to have out-patient departments. The use of out-patient services therefore varies even more widely among the counties than the use of hospital beds, and in the rural districts is probably at present a negligible factor in the care of illness of indigent patients.

Hospital and Clinic Distribution by Counties

A. Beds in General Hospitals. Of the 67 counties in Pennsylvania, there were 12 in which there were no local general hospitals giving free service. These twelve are Bedford, Cameron, Clarion, Forest, Fulton, Juniata, Perry, Pike, Snyder, Sullivan, Tioga and Wyoming. Seven of these 12 counties are about half way between Philadelphia and Pittsburgh, from Tioga in the central part of the northern border to Fulton, in the central part of the

southern border. In Tioga County, however, there is the Blossburg State Hospital of 91 beds, with an out-patient department. While this hospital is not limited to Tioga County residents, it doubtless cares for many of them. There is also an eleven-bed proprietary (private) hospital in Tioga County. There are two proprietary hospitals in Bedford County, where in an emergency an indigent patient might receive free care. In these two, there were 51 beds, according to the American Medical Association Directory. Furthermore, although there are no local general hospitals in Sullivan, Tioga or Wyoming Counties, the Robert Packer Hospital in Bradford County, with more than 300 beds, serves these neighboring counties to some extent.

In 19 counties there were from one to less than two beds per 1,000 population, and in four other counties were small hospitals providing less than 1 bed per 1,000. These 23 counties are Adams, Armstrong, Beaver, Bucks, Butler, Carbon, Centre, Cumberland, Fayette, Franklin, Greene, Indiana, Monroe, Northumberland, Potter, Schuylkill, Somerset, Susquehanna, Union, Washington, Wayne, Westmoreland, and York. One bed per 1,000 population is the most usual provision in Pennsylvania counties. Allegheny County is practically surrounded by such counties. There are four such in the south central part of the state, and a band of them from the center part running up to Wayne County in the northeastern corner.

There were 15 counties that had between 2.0 and 2.9 beds per 1,000 population. These were Berks, Blair, Clearfield, Dauphin, Delaware, Erie, Huntingdon, Jefferson, Lackawanna, Lebanon, Mercer, Mifflin, Northampton, Venango and Warren.

There were 11 counties that had between 3.0 and 3.9 beds per 1,000 population, Cambria, Chester, Clinton, Columbia, Elk, Lancaster, Lawrence, Lehigh, Luzerne, Lycoming, and Montgomery. For the entire state, the beds per 1,000 population number 3.96, but only these eleven counties and six others had 3 or more beds per 1,000 population.

In Crawford and McKean Counties there were from 4.0 to 4.9 beds per 1,000 population. Crawford is listed as having one local general hospital in Titusville, and two in Meadville. McKean County has two such hospitals in Kane, and one in Bradford.

There were four counties whose hospitals provided 5 or more beds per 1,000 population. Montour County, with only 15,200 population, has the highest rate per 1,000 population, 11.97, because of the location in Danville of the George F. Geisinger Memorial Hospital of 182 beds. The Geisinger Hospital is not limited to Montour County residents, but serves all the central part of the state.

Another county with a large hospital and comparatively small population is Bradford. Because of the Robert Packer Hospital in Sayre, a hospital of 325 beds, Bradford County has 6.34 beds available for each 1,000 of its population. Bradford County is surrounded by counties with little or no hospital provision, and the Packer Hospital draws from hundreds of miles beyond the county border.

The other two counties with 5 or more beds available per 1,000 population are Allegheny and Philadelphia, having 6.85 beds and 5.83 beds per 1,000 population, respectively. Hospitals in these areas also draw from districts far beyond their county borders.

When the 2,689 beds in state-owned and state-operated general hospitals are included with the local general hospitals, Pennsylvania has 39,861 hospital beds available for its 10,066,000 population, a rate of

3.96 per 1,000 population. In thirty proprietary general hospitals there were 1,078 additional beds, the larger ones being in Philadelphia, Pottsville (Schuylkill County), and Look No. 4 (Washington County). Beds in proprietary hospitals are usually not available for free work and have therefore not been included in these tabulations.

In a state report made in 1919, to show facilities for health and sickness needs in Pennsylvania, and in many reports since that time, the standard of five beds per 1,000 population has been set as the number to meet needs for hospital services. Pennsylvania does not meet this standard, and there are large areas where hospitals are not available without miles of travel.

B. Beds in hospitals providing other than general care. In addition to the beds in general hospitals, there are 35,105 beds in 28 mental institutions, 11 of which are state hospitals, one a Veterans' Administration Facility Hospital and one is a large training school for mentally deficient children.

There were 4,254 beds in 18 hospitals and sanatoria caring for tuberculous patients, according to the 1936 American Medical Association Directory. Three of these were State Sanatoria, and 5 were county institutions. There are a number of hospitals listed under "general" or "all others," that have beds for tuberculous patients also. The Pennsylvania Tuberculosis Society states that there are 6,336 beds in Pennsylvania for the care of tuberculous, including those in all types of hospitals, sanatoria, and preventoria.

The last group to be considered are the institutions providing care for special illnesses other than mental diseases and tuberculosis. Exclusive of proprietary special hospitals, there are 56 of these, many of which are not limited to care of residents in counties in which they are located. There are 9,047 beds in these special hospitals. They provide care for children, convalescent and rest patients, drug and alcoholic patients, epileptic patients, eye, ear, nose and throat patients, aged persons, incurables, isolation needs, maternity patients, orthopaedic care, skin and cancer patients, and venereal disease patients. They also include hospitals in prisons and reformatories and school infirmaries.

The total number of beds, including those in general hospitals and those caring for special diseases and conditions were 88,267.

Total beds	88,267
General hospitals	39,861
Mental institutions	35,105
Tuberculosis sanatoria	4,254
Other hospitals and institutions	9,047

This gives a rate of 8.77 beds per 1,000 Pennsylvania inhabitants. The generally accepted yardstick for beds per 1,000 population, for all types of illness, is 11 or 12 beds. Pennsylvania does not meet this standard.

C. Days of Free Care in General Hospitals. The total number of days of free care provided in general hospitals in the state was 5,734,462 days, of which 622,957, or 10.9 per cent, were in hospitals considered state-wide in these calculations. The days of free care per 1,000 population for the state were 569.7. There were, however, only 4 counties that exceeded this measure, - Allegheny with 1,316.8, Philadelphia with 803.4, Bradford, the county of the Robert Packer Hospital drawing from many districts, with 788.1, and Luzerne, because of the large hospitals in Wilkes-Barre, with 688.5. In Montour County, in which is located the George F. Geisinger

Memorial Hospital, there were 544.6 days of free care per 1,000 population. Northampton County provided 420.2 free days per 1,000 population.

These are the counties that stand out in this calculation of the possible provision of free care in each county. It is evident that the 623,000 days, estimated to be provided by state hospitals giving general service, account for the fact that the state average is as high as 569.7. In twelve counties, no days of free care were provided by local general hospitals; in twelve counties less than 100 days per 1,000 population were provided; in 21, between 100 and 200; in 11, between 200 and 300; in 5, between 300 and 400; and in 6, more than 400.

D. Out patient Visits to General Hospitals and to State and City Health Department Clinics. From the Pennsylvania Hospital Association schedules, supplemented by some questionnaires sent out by this Committee, and including estimates for 38 hospitals from which out-patient visit data were not available, the figure of 3,438,618 out-patient visits to the 206 general hospitals is obtained. It is surprising that this is lower than the number of days of free care in these hospitals, which was over 5,700,000.

There are other agencies providing dispensary facilities, particularly the State and Municipal Health Departments, the Falk Clinic in Pittsburgh, the Henry Phipps Institute in Philadelphia, and the Kirby Memorial Health Center in Wilkes-Barre. More than 380,000 visits were made to clinics in 1935 in three major services operated by the State Department of Health, as follows:

Three services	383,780
Tuberculosis dispensaries	54,056
Child Health Centers	69,342
Genito-urinary dispensaries	260,382

Many of the State and City Health Department Clinics are in general hospitals. Those departments furnished data about number of visits by address of clinic, and we were able, therefore, to avoid the duplication of including these visits in the reports of both tho hospitals and the Department of Health clinics. There were about 780,000 clinic visits, in addition to those reported by General Hospitals, which increases the number of visits to 4,218,299, a figure still below the number of days of free hospital care in the state.

The number of clinic visits per 1,000 population was 419.1. Only 6 counties had rates above that of the State as a whole. Philadelphia is evidently peculiar in Pennsylvania in its use of clinics. According to the figures of this study, the clinic visit rate per 1,000 population was 1,155.4 per year, a figure almost 3 times that of the state as a whole, and far in advance of the next county, Montour, which had a rate of 797.3. Berks showed 658.2, Bradford 553.2, Dauphin 481.9, Lehigh 470.3. The hospitals in Allegheny County reported a peculiarly low number of clinic visits, and further investigation is needed to explain the rate of 321.0 clinic visits per 1,000 population, particularly when this is compared with the high rate of days of free care, 1,316.8 for this county.

While there were 12 counties that have no local general hospitals providing free care within their borders, there are only 5 counties that apparently have no clinic facilities. These are Perry, Pike, Potter, Sullivan, and Union. In Union County the Directory lists a United States Public Health Service Hospital doing general work and having an out-patient department, but this is considered in this study to be a state-wide institution. There are 38 counties where less than 100 clinic visits per 1,000 population were made. These 38, and the 5 where no clinic visits were made,

are the counties in which the service of private physicians is obviously of special importance. These 43 counties represent nearly two-thirds of all the 67 counties in the state. Of the 43, 21 were in the western part of the state, 4 in the central part, and 18 in the eastern part.

A comparison of the rates of days of free care and clinic visits per 1,000 population shows that in 27 counties the days of free care are significantly above the clinic visits. In 34 counties there is no significance in these comparisons. In the other 6, Berks, Dauphin, Lehigh, Montour, Philadelphia and York, the comparison shows a greater use of clinic facilities, since the number of clinic visits is significantly above the number of days of free care.

These comparisons show the heterogeneity of the State, and the variations of facilities and possibly of attitudes towards clinic service. It is recognized that more critical analysis of the original data of this study, if time allowed, might provide a clearer understanding of the hospital and out-patient situation in Pennsylvania. Little attempt could be made in this study to define and keep the term "clinic visit" absolutely comparable throughout, and no attempt could be made to classify the clinic visits by type of service. There may also be variations in the types of service given in the "days of free care", in that while many hospitals are limited to surgical and acute medical work, others termed "general hospitals" may include in their facilities care for chronic diseases, such as tuberculosis, and care for the aged. Such inclusions would send the number of days of free care per bed far higher than if only surgical and acute medical work were done.

Supplementary Data

Since the completion of Table 16 which shows the volume of free out-patient work done by the hospital clinics during the year 1935, results have been received of a recent survey conducted by Mr. Melvin L. Sutley, President of the Hospital Association of Pennsylvania, and a member of this Committee, which throws much needed light on this subject.

Tabulations were possible concerning 58 hospitals returning the Sutley questionnaire. These hospitals were distributed widely throughout the state. The time covered was for the complete calendar year of 1936. The State Medical Relief Program was in operation for 9 months during this year.

The results of the tabulations can be summarized as follows:

279,863 persons made 966,406 visits to 48 hospital out-patient departments.
151,569 of these persons, or 54.2%, were relief clients, and made
591,809 visits, or 61.2%, of all visits made to the clinics.

During the first 9 months of 1936, there were 443,855 visits to the out-patient departments of these 48 hospitals*, during the period when 640,295 visits to private practitioners were made on medical relief orders throughout the state.

*There are about 135 hospitals in the state which operate out-patient departments. It would not be correct to say that the above figures represent 35 per cent of all the hospital work done in the State, as the list of the 48 which responded to the questionnaire were the larger hospitals.

State Aid to Private Hospitals

As we have seen, a great part of the free medical care given to the indigent is supplied in hospital wards and hospital clinics. Many hospitals in the State of Pennsylvania receive a certain amount of State aid to help defray the expense of this service. Money thus received from the State cannot be paid to the physician who actually treated the sick in the hospital, nor is it intended to finance any portion of the dispensary service.

State appropriations to hospitals are presumably roughly based on the cost of supplying an approved day of free bed care, modified by such factors as the type of community, the size of the hospital, other means of local support, and the like. The maximum allowance by the Commonwealth for such a free day is $3.00, but actually very few hospitals receive this full amount. According to the 1933-35 appropriation figures, the hospitals average $1.44 for each free bed day of service, this figure having been reached by dividing the total number of free days of all the aided hospitals, into $7,500,000, the amount set aside in the budget for State aid during the 1935-37 biennium.

From the beginning of State aid to private hospitals in Pennsylvania, there has been little attempt made to allocate funds upon the basis of thorough systematic study, and the distribution has often been a major logrolling item in the Legislature. It has been much discussed, and many proposals for systematic reform have been made.

In December, 1934, the attention of the Commonwealth was again directed to this complex problem by the "Report on State Aid to Private Charitable Institutions and Agencies", made by the State Welfare Commission and submitted by Alice F. Liveright, then Secretary of Welfare, to Governor Pinchot who later presented it to the members of the General Assembly. This report, among other things, recommended that the State assume some definite part of the cost of out-patient service in private hospitals and that this aid be given on an equitable basis and, as far as possible, on the basis of service rendered.

State-aided institutions have usually received less than fifty per cent reimbursement of actual cost of free care from State funds. Some hospitals received as high as 100 per cent and others as low as 5.1 per cent; the average for the entire 163 hospitals was 48 per cent.* Some of these hospitals receive additional funds from local community chests and local governments, but the State's appropriation has covered less than fifty per cent of the approved free days of care in these 163 hospitals and has assisted in no way in defraying the expense of operation of the out-patient departments and clinics.

The widespread belief, therefore, that indigent persons could be freely referred to the wards and clinics of State-aided institutions, on the ground that these hospitals are receiving State appropriations which would cover the cost, is only partially correct. If the indigent person so referred goes to the out-patient department of a hospital, the State contributes no money to cover the expense of the service, and if the patient is admitted to the ward of the hospital, approximately one-half of the expense for this care is paid by State funds. Furthermore, of the 236 general hospitals in the State of Pennsylvania, only 163 receive State aid.

The Committee on Appropriations of the House of Representatives, Representative Herbert B. Cohen, chairman, made a study in 1935* of the

*Summary of a Study of State Aid to Private Hospitals made by 1935-37 Appropriation Committee of House of Representatives of Pennsylvania.

injustices of the existing practice of distributing funds to the 163 state-aided hospitals, in an effort to determine a systematically equitable method of procedure to guide this and future committees, in recommending allocations to such institutions. The Committoe concluded that the situation cannot be completely rectified suddenly at one session of the legislature without seriously disturbing the function of free service in many of the hospitals which have been favored with a disproportionately large share of state aid. An abrupt readjustment might prove to be as unfair in its effect upon certain institutions, and the public they serve, as has been the logrolling practice of the past.

Nursing Facilities

Nursing facilities at the present time throughout the State are not organized on a county basis. An attempt was made, under the Medical Relief Program, to set up a nursing organization having a central committee at Harrisburg, with separate organizations in each county to provide a bedside nursing service to relief clients. This ideal was never fully realized, but in all counties except one, a nursing committee was formed with an appointed chairman.

Since the termination of the Medical Relief Program, the situation has largely reverted to its former condition except that the medical relief nursing committees have been held together in each county. They are inactive at present, but are ready to assist in any nursing program which may be set up for the indigent.

In the absence of the relief board medical program, the poor people who need nursing care in the home must obtain it as charity from either the Visiting Nurses Association, the community nurses*, from the Red Cross Nursing organization, or, occasionally, from State nurses.

The Bureau of Nursing of the Pennsylvania Department of Health has approximately 120 field nurses working throughout the State. In 1935 they made a total of 204,973 visits. These visits were divided as follows:**

Total visits	204,973
Tuberculosis	50,489
Child Health	38,314
4th Class Schools	42,216
Genito-urinary	6,471
Pre-natal	4,266
Weighing & statistics	3,072
Heart and Cancer	521
All others	59,624

*A community nurse may supply the following types of nursing service: School nursing and well baby conferences; assist with tuberculosis clinics; supply bedside nursing care; supervise health in families. A community nurse may be supported in whole or in part by: Community Chest Fund (or its equivalent);Red Cross Funds; Tuberculosis seals sales; School Board; Local Health Department; Insurance Company contract; Patients' fees.

**Figure obtained by personal communication from Pennsylvania Department of Health, March, 1937.

There are 27,066 registered nurses who had renewed their registration up to January 1, 1937.* This includes all types of nurses, i.e. private duty, institutional, public health nurses, industrial nurses, school nurses, etc., some of whom are inactive and many of whom would not be available for bedside nursing care to indigent clients.

The National Organization for Public Health Nursing in its 1934 survey reports that the minimum essential in establishing adequate public health nursing service for individuals is a ratio of one nurse to every 2,500 persons in the population. There are now available for bedside nursing care throughout the state approximately 500 public health nurses.**

For an estimated relief load of approximately 1,500,000 persons, 600 public health nurses would be required according to the above ratio, to take care of the indigent alone. The remaining 8,500,000 persons in the state who are not on relief would require 3,400 additional public health nurses. This clearly shows the inadequacy of nursing facilities in the State at the present time.

Another aspect of the inadequacy which is not brought out by the above figures is the uneven geographical distribution of the available nurses throughout the State. There are many areas which are practically barren of nursing facilities, where persons are forced to go without nursing services, however urgently they may be needed.

The cost of providing a routine bedside nursing visit has been carefully worked out by visiting nursing associations and other organizations that enter into contracts with insurance companies to provide service to their clients. The cost per visit varies somewhat from place to place, but the average for all areas is about $1.10 a visit. In rural areas, where the population is widely distributed, some added provision for transportation is necessary.

Under the relief board medical program, authorized nursing visits were compensated for at the rate of 85 cents per visit, and limited to 10 visits in any acute cases. No increased allowance was made for long trips, where the cost of transportation alone often exceeded 85 cents. As a result of this and of expenses incurred by supplying more than the maximum 10 visits in the most desperate cases, some of the nursing organizations were forced to restrict their participation in the relief program.

The following 14 counties are partly covered with organized services for bedside nursing care: Allegheny, Berks, Chester, Dauphin, Delaware, Erie, Lackawanna, Lancaster, Lebanon, Luzerne, Montgomery, Northampton, Philadelphia, and York.

The following 7 counties have one or two areas in which organized bedside nursing care is fairly well provided: Adams, Bradford, Carbon, Cumberland, Lehigh, Schuylkill and Warren.

The following 23 counties are very inadequately covered, but have isolated agencies which can provide bedside nursing care: Beaver, Bedford, Blair, Bucks, Cambria, Center, Clearfield, Columbia, Crawford, Fayette, Huntingdon, Jefferson, Lawrence, Lycoming, Mercer, McKean, Monroe, Montour, Northumberland, Susquehanna, Venango, Washington, and Westmoreland.

*Official figures from Department of Public Instruction, March, 1937.

**Committee on Nursing Care for Recipients of Relief. Miss Ruth Hubbard, Chairman, June 25, 1935.

The following 23 counties have no organized bedside nursing facilities: Armstrong, Butler, Cameron, Clarion, Clinton, Elk, Forrest, Franklin, Fulton, Greene, Indiana, Juniata, Mifflin, Perry, Pike, Potter, Snyder, Somerset, Sullivan, Tioga, Union, Wayne, and Wyoming.

Dental Services

The Need for Dental Care of Children

Adequate dental care to children during the time of their growth and development is very important, as it not only corrects existing defects at an early date and thus prevents irreparable damage, but also results in a beneficial effect upon the general health of the child. Dental care and oral hygiene inaugurated early in tho life of a child may result in the formation of healthful habits throughout life.

The actual need for dental care among children is shown by a survey made in 1933 and 1934 in 44 Pennsylvania counties. It was made by practicing dentists, in cooperation with the U. S. Public Health Service. A total of 75,383 children were examined and the results tabulated. Summarization of the data for Pennsylvania areas gives the following results:

Table 7

Dental Needs and Treatments*

Present Dental Needs		Variation in different areas
1. Treatment needed	over 93%	62-100%
2. Prophylaxis needed	" 67%	25-94%
3. Gingivitis	" 5%	0-15%
4. Caries deciduous teeth	" 30%	2-60%
5. Caries permanent teeth	" 70%	15-89%
6. Extractions indicated (deciduous teeth)	" 45%	5-60%
7. Extractions indicated (permanent teeth)	" 75%	30-85%
8. Malocclusion slight	" 25%	10-46%
9. Malocclusion severe	" 7%	1-25%
10. Orthodontic treatment needed	" 15%	1-42%
Past Dental Treatment (prior to exam)		
Total having received it: 60% (from 15-95%)		Variation in different areas
1. Odontexesis (History of)	over 65%	7-100%
2. Fillings present	" 40%	2-75%
3. Fillings deciduous teeth	" 33%	0-65%
4. Fillings permanent teeth	" 33%	5-64%
5. Extractions permanent teeth	" 25%	10-40%

From the records of the Emergency Child Health Committee, the incidence of dental caries, as discovered by physicians in their routine health examinations, was 42.2 per cent. This figure was obtained from examinations of 118,018 children, of whom 49,811 showod easily recognizable dental caries. The figures of these two studies show the almost unbelievable need for dental attention among Pennsylvania's future citizens.

*Public Health Bulletin #226, "Dental Survey of School Children, ages 6-14 Years, Made in 1933-34 in 26 States."

The Need for Dental Care of Adults

The need for dental care in the adult population cannot be presented in so striking a way as in the case of children, because no systematic surveys of this class have been made. Under the State Emergency Relief Board medical program, in which dental services were limited to treatment of acute conditions requiring extractions and fillings, there were 300.6 dental orders issued to every 1,000 cases on relief in the State, during the year 1935.* For the entire medical relief program of 34 months, in any 12-month period there were 261.2 dental ordors issued for each 1,000 cases on relief. These figures indicate the need of urgent dental care among adults. It is safe to say that all adults should have some sort of dental attention each year and about one-third will urgently require emergency extractions and treatment for acute toothaches.

Adequate Dental Care Consists of:

1. The removal of hopelessly diseased teeth;
2. Prophylactic treatments;
3. Filling of all caries;
4. Pulp canal work whon indicated;
5. Restoration of missing teeth to establish proper mastication and improve appearances;
6. Restoration of mouths devoid of all toeth with full dentures;
7. Any other oral treatments necessary to maintain or restore the general health of the individual.

Present Dental Facilities in the State

There are only 6,852 licensed dentists in the state of Pennsylvania,** of whom probably 500 are not in active practice. This gives a ratio of about one active dentist to every 1,600 persons. This ratio should not be less than one dentist to 1,000 persons under present conditions, and more ideally it should probably be one dentist to about every 500 persons.

Private dental facilities are to be found scattered irregularly throughout the State, being more concentrated in metropolitan areas. Many rural areas are poorly supplied with private dentists. In addition to privato dentists there are dental clinics established and operating in many of the non-official hospitals throughout the State. The exact number and location of these hospital dental clinics has not been determined. The smaller hospitals rarely have an organized dental clinic. The larger hospitals are located in thickly populated urban areas. Here again the rural districts are left with inadequate facilities for dental care, as for nursing care, diagnostic and special medical facilities and adequate dispensary services for drugs and medical supplies.

*See Table 4 (page 24) and Table 12, in Appendix I.

**Figures from the Pennsylvania Bureau of Professional Licensure, March, 1937.

The dental activities of the State itself consist almost entirely of giving remedial and certain prophylactic dental treatments in some of the State sanatoria, mental hospitals, and penal institutions. Annual health examinations of children in fourth-class school districts are also conducted by the State. The physical examination includes a record of dental defects. There is no specific legislative authority for dental service, except the general authority vested in the Commissioner of Health to inaugurate nocessary health measures.

In first, second, and third class school districts, the medical inspectors are appointed and paid by local authorities, but they work under the supervision of the State Department of Health. Dental defects are recorded and tabulated and corrective or curative measures are recommended. Again, no specific treatment is undertaken.

In addition to the above mentioned facilities for dental care in the State, there are several non-profit dental clinics in operation in large cities, on a low fee cost basis. They usually do not have sufficient funds to extend their program to include any large part of the indigent population.

New Medical Relief Plans in Counties

At the termination of the State Emergency Relief Board medical program in September 1936, several local county medical societies in the State drew up plans for taking care of the State relief clients as well as persons on the Poor Board lists. These plans were confined to services rendered in the patient's home or the doctor's office, and therefore excluded services rendered in hospital clinics and county institutions or almshouses.

The characteristic features of various agreements now in operation in certain counties of the State are:

1. The County Poor Board (or the county commissioners) appropriate a definite amount of money annually for non-institutional medical care of the indigent, and turn over 1/12 of this amount each month to the County Medical Society (or other qualified group) to pay the current medical bills.

2. The books are closed each month on a certain date and all bills received up to this time are either paid in full or pro-rated according to the money available. In this way, nothing is carried over to the next month.

3. Free choice of physician is permitted.

4. A fee-for-service method of payment is used.

5. Patients are all certified in writing before coming to a physician for treatment (except in emergencies).

6. All differences of opinions relative to fees and regulations are settled by cooperation between the medical society and the Poor Board officials.

The agreement now in effect in Montgomery County is presented in detail in the appendix of this report, as an example of one of the most recent plans to be put into operation.

Part IV

The Future Problem

Estimate of Possible Load

In view of the fact that none of the programs of medical care so far discussed, nor all of them together, have aimed to meet completely the health needs of all citizens of the State who are unable to pay for necessary medical service, past experience is not a sufficient guide in formulating estimates of the extent and cost of a complete medical relief program. No such program has been systematically followed, for example, in the care of persons receiving old age assistance, mothers' assistance, or blind pensions, nor has a comprehensive effort been made to meet the health needs of persons employed on Federal Works Programs. Beyond these groups, who are receiving some form of public aid, is a further group of persons not now receiving other public assistance, who are able to maintain themselves at a minimum level under ordinary circumstances, but who, when sickness assails them or their families, are dependent upon public aid for meeting the extraordinary costs thus imposed. To meet these needs themselves would usually mean that other vital needs would not be met or that these families would require other public aid. In other words, they would either immediately or ultimately become dependent upon public relief.

The Pennsylvania Committee on Public Assistance and Relief in "A Supplemental Statement on Estimated Costs of Public Assistance", published on February 5, 1937, gave reasonable estimates of the monthly average number of persons who would receive public assistance in Pennsylvania during the year 1938. This estimate is as follows:

Unemployment Relief	339,000
Old Age Assistance	87,000
Mothers' Assistance (children)	42,900
Veterans' Relief	4,200
Blind Pensions	10,250
Total, Direct Relief	483,350
Works Progress Employees (with their families)	755,000
	1,238,350
To this number must be added those in the borderline group mentioned above who may require medical service for which they will be unable to pay. This number will probably amount to	1,071,500*
Grand total persons	2,309,850

*Computed from data in census of employable workers in urban and rural non-farm areas of Pennsylvania, April, 1934, including persons in families whose income is less than $625 a year after deducting those receiving direct or work relief.

Incidence of Illness in Indigent Groups

It is necessary for our purposes to form a reasonable estimate as to how many of these people will be ill and require treatment in a given period of time.

There are few reliable sources of facts and figures on the incidence of illness in the indigent and low-income groups. In the study, "The Incidence of Illness and the Receipt and Cost of Medical Care Among Representative Family Groups" by I. S. Falk, Margaret C. Klem, and Nathan Sinai, illness rates have been shown. This study, which was published in 1933 and covered a study of about 38,000 persons over twelve months, found that illness rates per year varied widely, according to age, sex and economic condition. For the group of persons probably eligible for free medical care under an assistance and relief program, the estimated illness rate is 82 illnesses per 100 persons per year. This does not mean that 82 per cent of these 100 persons will actually be sick, but that 82 illnesses will occur among each 100 of them, some having no illness and some perhaps five or six illnesses.

The actual variations in frequency of illness among the persons covered by this study were:

Number of Illnesses During 12 Month Period	Per cent of Persons Having the Specified Number of Illnesses
none	47.1
1	32.2
2	13.6
3	4.8
4	1.6
5 and over	0.7

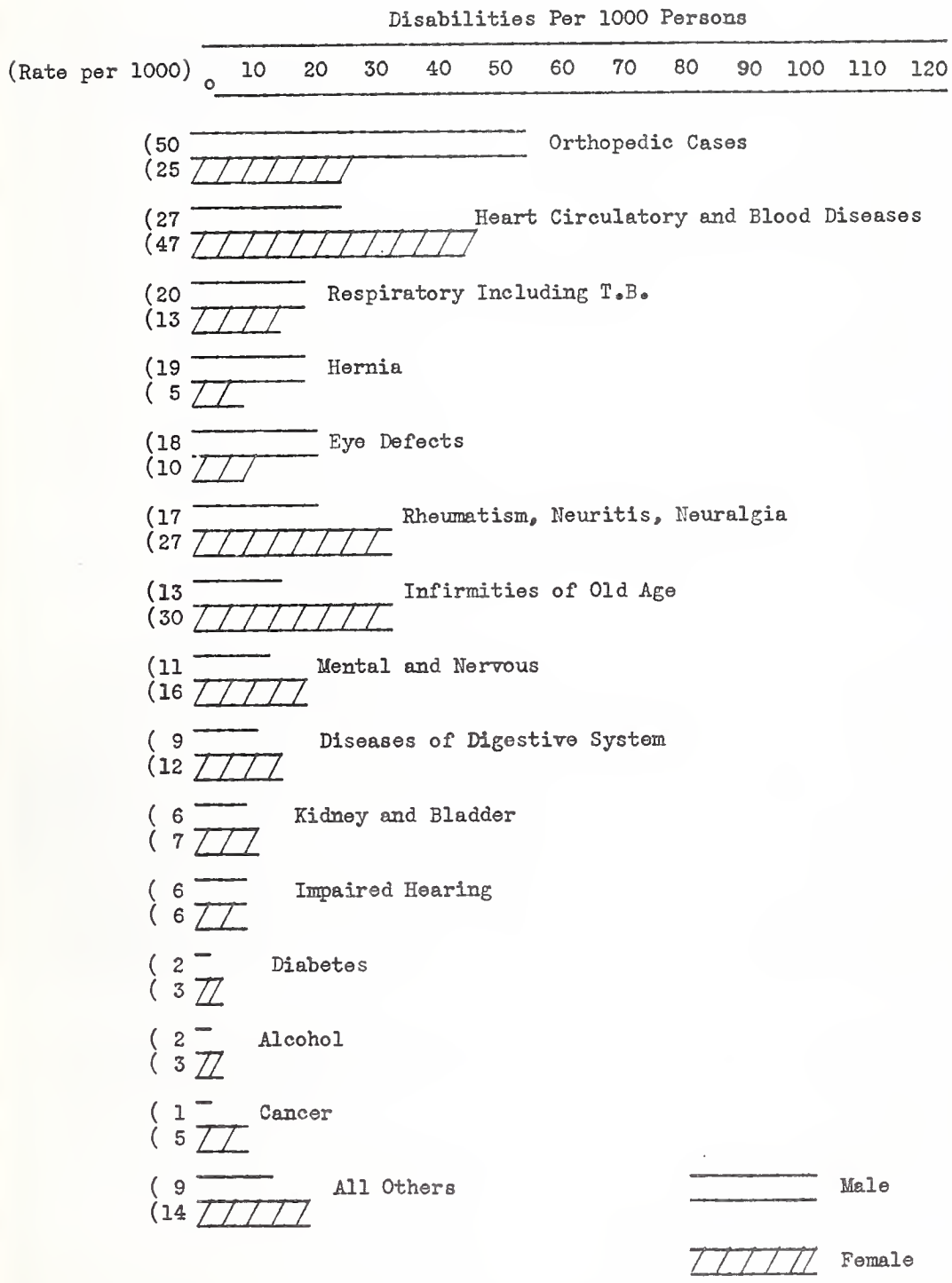
In the preliminary report of the Federal Emergency Relief Administration, (Division of Research, Statistics and Finance, May, 1935) on their study of "Disabilities in the Urban Relief Population," further information is given. The survey covered 169,000 relief cases in 79 cities in the United States. The cases were selected to be representative of the urban population and of the major industries in urban areas. The total urban relief population at that time was estimated at 2,800,000 cases. The canvassed group thus represents 6.03 per cent of the estimated total and was heavily weighted with skilled and unskilled laborers. The report on disability data is based on an analysis of 5 per cent of the above schedules. The information was not obtained by medical examination but by house to house canvass. The handicaps reported were presumed to be only such as constituted a serious physical or mental disability. Chart A portrays the disabilities by types, per thousand persons.

Results of the preliminary analysis show that 22 per cent of all relief persons who are 16 years of age and older reported handicaps which they considered serious. In the age group 16-64 years, eleven per cent of unemployed persons on relief or non-relief work had disabilities; 14 per cent seeking work had disabilities; 60 per cent of those not seeking work had disabilities. (See Table 8). In the age group of 65 or over, seventy per cent reported serious physical or mental disabilities.

In Dayton, Ohio, this same survey included non-relief as well as relief persons, and comparison of results showed that the prevalence of disabilities among relief persons was three times as great as among non-relief persons. These results tend to confirm those of a survey of illness among relief and non-relief families made by the United States Public Health Service in 1933, which showed a higher incidence of disabling illness among relief families than among families not on relief.

CHART A

Kind and Extent of Disabilities in Urban Relief Population 16 Years Old and Over*



*Facts taken from Report of Federal Emergency Relief Administration on "Disabilities in the Urban Relief Population", May, 1935.

Table 8

Prevalence of Disabilities Among Persons on Relief Aged Sixteen Years and Older

Per cent of Persons Reporting Disabilities*

Race and Sex	Total All Classes	16-64 Years of Age						65 Years of Age and Older
		Total 16-64 Years	Employed or Seeking Work				Not Seeking Work	
			Total	Non-Relief Work	WPA	Seeking Work		
All Races	21.9	18.7	13.6	11.6	11.4	14.4	28.5	70.1
Male	20.8	17.9	14.5	12.1	11.5	16.0	52.0	65.0
Female	23.0	19.5	11.5	10.8	10.2	11.7	25.0	75.1
White	21.9	18.6	14.2	11.9	11.9	15.3	26.1	68.9
Male	21.6	18.7	15.6	13.0	12.0	17.3	50.7	64.1
Female	22.2	18.5	10.6	9.6	10.7	10.8	22.7	73.7
Negro	23.4	20.5	12.1	10.8	9.3	12.7	46.4	75.9
Male	18.2	15.2	10.6	6.8	9.4	11.4	60.8	69.7
Female	27.2	24.3	13.7	13.0	8.3	13.9	43.6	80.7
Others	12.4	8.5	5.6	8.6	5.8	5.1	13.0	74.2
Male	12.4	9.2	6.9	8.0	6.2	7.0	35.0	66.7
Female	12.3	7.9	1.4	10.0	-	-	10.6	81.2

*Facts based on 5 per cent sample of schedules from the Survey of Occupational Characteristics of the May, 1935, Urban Relief Population, Federal Emergency Relief Administration.

From thirty-four months of experience with the State Emergency Relief Board in Pennsylvania it would be impossible to determine accurately the incidence of illness in the relief population of this State. The figures show merely that, on the average, 7 medical orders were issued each month for every 100 cases on relief. This indicates that an average of 3.08 medical orders were issued each month per every 100 persons on relief. Assuming that one-half of the illnesses among relief clients were treated in hospitals or clinics, this indicates a rate of 6.16 illnesses per month per 100 persons on relief or an illness rate of 739.2 per 1,000 persons a year. (This is in line with the figures from the study by Falk, Klem and Sinai, which showed 820 illnesses per 1,000 for all classes, including the old age assistance group. Their figures showed 780 illnesses per 1,000 persons for the relief group; 1,040 per 1,000 for the aged (65 years and over), and 810 per 1,000 for persons under 16.)

If these illness rates are applied to the estimated relief load in Pennsylvania for 1938, the following table gives, roughly, the annual incidence of illness which might be expected in the various classes entitled to relief under the proposed program:

Table 9

Estimated Number and Rates of Illnesses Per Year

Among Persons on Relief in Pennsylvania

Type of Program	Ages	Number of Persons	Number of Illnesses	Illness rate per 1,000 persons
Unemployment and general relief	All ages	339,000	264,420	78
Old Age Assistance	65 and over	87,000	90,480	104
Mothers' Assistance	Under 16	42,900	34,749	81
Blind Pensions	All ages	10,250	7,995	78
Veterans' Relief	All ages	4,200	3,276	78
Total (direct relief)		483,350	400,920	
Works Progress Employment	All ages	755,000	588,900	78
Total (direct and work relief)		1,238,350	989,820	
Border line group	All ages	1,071,500	835,770	78
Grand Total		2,309,850	1,825,590	

Cost of Medical Care

Under the State Emergency Relief Board program (34 months) the average cost per case for all medical care (including doctors, dentists, nurses, and pharmacists) not including administrative cost, was 54 cents per case per month or $1.98 per person per year. This expenditure is not indicative of the actual cost of a complete program, however, for a number of reasons. The program was limited in its scope practically to emergency services only; actual expenditures were arbitrarily limited by funds available; the program did not include care of the aged, nor of children in mothers' assistance families, nor of persons receiving blind pensions; it did not provide throughout the State for adequate dental or nursing care, nor did it include provision for hospitalization or for many important special services.

Comparison with expenditures in other States for programs in general like Pennsylvania's, and for the unemployed alone, show the Pennsylvania expenditures as somewhat lower than others for which reports are readily available. In New York State, under the Temporary Emergency Relief Administration, expenditures amounted to $2.00 per person per year. In the State of Iowa, where a somewhat more liberal program was conducted, the cost, apart from administration, rose to $4.80 per person per year. In Oakland County, Michigan, where a still more liberal plan, including medical care of persons certified as entitled to medical relief alone, is in effect, the cost per person per year was $5.16.

Various estimates as to the cost of complete medical service for families of low income groups are available. Such a service would include necessary treatment by physicians, dentists, nurses, hospitals and other

special services, such as those of surgery and consultation and diagnosis. The report of the Committee on the Cost of Medical Care, in 1933, estimated the average expenditure for such service for low income groups at $26.88 per year. A survey in New Hampshire, by the United States Bureau of Labor Statistics, produced an estimate of expenditures on a similar basis of $19.80 per person per year. A similar survey in certain areas of Pennsylvania, under the same auspices, resulted in an estimate of $34.44 per person per year.

A study of 18,527 persons of low income groups in California (1933-35) by Miss Margaret C. Klem, produced the following figures:

Table 10

Expenditures for Medical Care of Low-Income Families in California*

Economic Level		Average Three-month Cost per family**	Per cent of Total Cost expended for				
1929	1933		Doctors	Dentists	Hospitals	Nurses	Others***
Moderate	Moderate	$17.26	33.6	25.7	17.8	1.5	21.4

* "Medical Care and Costs in California families in relation to Economic Status", by Margaret C. Klem, Appendix Table 47, page 112.

** Average composition of family: 3.6 persons.

*** Includes chiropractors, osteopaths, and practitioners representing various sects and specialties.

The "Study of Incidence of Illness and Receipts and Costs of Medical Care", by Falk, Klem and Sinai, shows that in 8,500 families studied, medical charges constituted 5.9 per cent of the entire family income for the lowest income group (under $1,200 a year) and 3.7 per cent of the entire family income for the highest income group ($10,000 and over a year). The general average for all families and all incomes and all communities was 4.2 per cent of total family income. This figure may be helpful in estimating how much a health program may be expected to cost. For the definitely indigent class, a complete health service would be an item which would probably amount to about 5 per cent of the entire family budget.

Assuming an annual expenditure of $25.00 for each family receiving relief or entitled to free medical care under the proposed program in Pennsylvania, the cost would be not less than $15,000,000 per year. If, from this total, present State and local governmental expenditures for hospital care, public clinics, and certain other public medical services, included in this total program, are deducted (amounting to at least $5,000,000 a year), the needed additional expenditure required may be conservatively (very roughly) estimated at $10,000,000.

For the group of persons actually expected to receive other forms of public assistance during the next year, from $5,000,000 to $7,000,000 in addition to customary public appropriations, would probably insure reasonably adequate care. This would compare with estimated expenditures for medical care, excluding cost of administration, under the recent State Emergency Relief Board program, of about $3,000,000 per year, in addition to administrative

costs. These estimates are necessarily rough and subject to many possible differences of opinion, differences of standards, differences of local conditions and differences of rates of compensation for various services. Only actual experience and experimentation will afford adequate basic data for accurate prediction of future costs.

Part V

Conclusions and Recommendations

1. That medical care (services of the healing arts professions) is an integral and indispensable part of any sound program for the public relief and assistance of persons unable to maintain themselves at a minimum level of health and decency.

The conservation of public health and the promotion of the general welfare justify provision of adequate medical care of those in need as an obligation of government. Governmental responsibility exists in the same measure for members of families when they become ill as when they are well, and illness, which inaugurates a more expensive and difficult condition, does not alter or diminish this governmental responsibility.

The healing arts professions have long recognized and assumed a large responsibility for care of the sick who are unable to pay for treatment. Such responsibility is a part of the special ethics of the professions, and so well has it been borne in practice that both the members of the professions and the lay public have come to expect, as a matter of course, that patients will be served, when necessary, whether or not they can pay for the service.

The healing arts professions alone, however, cannot carry the whole burden of care of the indigent sick. So great is the demand for the service that members of the professions cannot and should not meet it wholly at their own expense.

2. That a State-wide service for this purpose should be provided, designed to meet, as nearly as possible on an equal basis, the needs of all such persons.

Many of the smaller divisions and subdivisions of the State, if left to their own resources and initiative, not only would be financially unable to set up and maintain an adequate health service for those in need, but would create a hodgepodge of services which would often be extravagant, overlapping, and inefficient.

The medical relief program should be supervised by the department of the State government which will administer general relief, but it should be so organized as to leave a wide latitude of administrative freedom, under the supervision of the healing arts professions.

3. That such a program should, so far as possible, serve:

   (a) Those receiving other forms of public assistance;
   (b) Other persons certified by the County Assistance Boards as unable to provide for themselves such necessary services as are included in the program.

Such a program should serve the health needs of persons receiving not only general assistance (unemployment relief and poor relief) but also those receiving work relief (Works Progress Administration), veterans' relief, mothers' assistance (aid to dependent children in their own homes), old age assistance, and blind pensions, where necessary.

The right of all these persons to receive public aid, by reason of their economic status, has been established by investigation. As it has been proven that they are financially unable to provide themselves with other basic necessities of life, such as food or shelter, it is obvious that they will be unable to pay for medical attention when sick. For estimating the problem of this group a great deal of factual information is available. They have been counted and studied by many agencies and organizations for years.

In the economic group just above this level are many persons who are living on the lowest subsistence basis. These persons are on the borderline of independence. They are just able to maintain themselves without help at a level of existence which the standards of public assistance organizations accept as tolerable. Their position is a precarious one, however; any misfortune upsets their balance and they quickly fall back into dependency. When illness strikes such a family, especially if it affects the breadwinner, the members are unable to provide themselves with the necessary medical attention, and unless some provision is made to supply it to them they will soon increase the rolls of those on relief. These persons should not be classified as "sick poor people" but people who are "poor when sick". The number and extent of the "borderline" class of persons is unknown. It is a relatively uncharted field. In planning to include them in a health program designed for the indigent, it is realized that the problem of care and of cost is largely increased.

In spite of these difficulties, it is, nevertheless, considered necessary and desirable to make provision for their care when sick, in order to enable them to maintain their economic independence. It is believed that these persons could apply and be certified for medical attention alone, after a routine social and economic investigation by a relief agency. This procedure would serve to prevent abuses and also to make it possible in time to obtain factual information upon which more definite plans could be made hereafter for this group.

At any rate it seems foolish to require such a person to establish his inability to provide himself with some other necessity of life, such as food, shelter, or clothing, before being entitled to receive medical care. Such a policy provides an inducement for joining the relief rolls and for sacrificing all economic independence. Furthermore, it is this borderline class of persons who are most neglected from a health point of view. Provisions for sickness have been often provided for the definitely indigent, and financially independent persons will provide it for themselves. The person on the borderline is working and making an effort to keep off the relief rolls, and should be helped.

4. That this program should, so far as possible, supply a complete service including:

   (a) Preventive service, utilizing in this connection regular health agencies, and
   (b) Corrective and curative service, including medical, dental, nursing, clinical, hospital, and pharmaceutical services.

A health program in order to be of real value either must itself take care of all phases of illness and disability or must be correlated with other organizations supplying necessary services. It should be the aim of a health program to recognize and utilize all existing health activities, such as those of the State and local Departments of Health, the United States Public Health Service, public rehabilitation services and others, only entering the field of work covered by these departments when absolutely necessary to fill a gap.

The human body is subject to a great variety of diseases, requiring an even greater variety of diagnostic procedures and methods of treatment. A health program which can only cope with a situation when it is acute and can be adequately treated at home, but which cannot concern itself with such a problem when it becomes chronic or when it requires hospitalization, surgery, or some special diagnostic procedure, is obviously inadequate.

At the present time, the health of the indigent and borderline population does not suffer so much because of lack of proper facilities to take care of their needs, as from the lack of proper financial arrangements to enable them to use the facilities already set up. In some parts of the State, it is true, necessary facilities for the diagnosis and treatment of diseases are very scant. In these areas some effort should be made which will lead to the establishment of basic health facilities to serve the whole community, such as hospitals with diagnostic and surgical clinics, nursing organizations and dental clinics.

The Dental Profession, represented by the Board of Trustees of the Pennsylvania State Dental Society, desires the opportunity to work out with the State Department of Assistance a plan that will provide:

(a) Adequate service for children;
(b) Emergency service for adults, with the provision for supplying restorative work when authorized by the County Board of Assistance.

The Dental Profession feels that there is no single program that can be applied with equal effectiveness to all parts of the state. For this reason they will offer for consideration to the State Department of Assistance plans, made up in conjunction with the several County Boards of Assistance, that will best meet the situation peculiar to each local area.

The Dental Profession realizes the fact that funds available for medical care at this time will not permit the establishment of as complete a program as is thought desirable. Nevertheless, as a matter of record, and with the hope for a progressive expansion in the coming years, the following statement is made:

In supplying dental service to children whose families are unable to purchase this aid, any program of public assistance in the health field should emphasize preventive measures and the early correction of dental disease.

Adults who may be returned to gainful employment should receive a minimum of dental care, and that only for the relief of pain, the elimination of infection, or such restorative dentistry as will aid in their return to gainful occupations. The determination of employability shall be made by the County Board of Assistance.

For those persons who are unemployable and in the opinion of the County Board of Assistance cannot be returned to economic society, a more complete dental service should be provided to insure comfort and safety to health.

5. That the organizational framework of this program be based upon the county unit of administration, with a liberal allowance of local autonomy in administration and experimentation.

The organization should be set up with a central body as shown:

Department of Assistance

Central
Medical Bureau

Central
Healing Arts Committee

Central Medical Committee	Central Dental Committee	Central Nursing Committee	Central Hospital Committee	Central Pharmacy Committee	Central Osteopathic Committee

Each individual county should have a similar set-up, that is, a central Healing Arts Committee, consisting of representatives of the following subcommittees: (1) Medical Advisory Committee, including osteopathic representation; (2) Dental Advisory Committee; (3) Nursing Advisory Committee; (4) Pharmacists Advisory Committee; (5) Hospital Advisory Committee, where possible and necessary. The county committees should be definitely coordinated with corresponding central committees.

6. That the general scope, standards, and forms of operation should be determined by the State, through the appropriate department.

In determing the scope, standards and form of operation for the program, the State officials should freely consult with the central committees of the organized professional groups.

7. The State office at Harrisburg should outline basic rules of operation for the program and the local county committees should supply the detailed procedures of operation which apply to their respective areas.

The professional groups should be consulted in deciding upon the basic rules. Provisions should be made for changing the rules in the future, if necessary, without involving too many tedious and complicated procedures. Such a project as this complete medical program is still in an experimental stage and it is impossible to be sure that any set of rules accepted today will meet the approval of administrative officers and committees in the future.

8. That the program should provide, unless otherwise specified as the result of an agreement between the Department of Assistance and the professional group involved, for the free selection of licensed or registered physicians, dentists, nurses, hospitals, clinics, pharmacists, or other qualified organizations set up by, operated, and controlled by the healing arts groups participating in this work.

The maintenance of the individual "doctor-patient relationship" is deemed by most members of the healing arts professions as an essential condition of satisfactory professional service, on the ground that it assures a mutual confidence and understanding which is exceedingly important in diagnosis and treatment. The right of the patient to turn to a practitioner of his own choice is deemed an important factor in the establishment and maintenance of such a relationship.

With respect to hospitals, dispensaries, nursing organizations, in many districts dental service, and almost everywhere the highly specialized services, such as surgery or complicated processes of diagnosis and treatment, there can not be a wide choice by the patient, for relatively few, often only one or two, of suitable agencies or practitioners in these fields are available. Special clinics and organizations, sponsored by the special professions, as in the field of dentistry or nursing, for example, may consolidate and expand the efforts of individual members of these professions to make fruitful service widely available, if conducted on a high professional level and with a proper degree of individual responsibility on the part of practitioners, under the supervision of appropriate professional bodies.

The purpose of this recommendation is to leave patients as free as possible to seek the service they need wherever it is available and to leave members of the several healing arts professions as free as possible to serve patients in accordance with sound professional standards and with reasonable compensation.

9. That payment should be made on the fee-for-service principle, so far as practicable, and that all necessary adjustments of bills should be according to some predetermined plan.

10. That all participating professional persons should be given the benefit of a hearing before their own professional group before any official disciplinary measures are enforced.

When questions of irregularities of practice arise, involving real or apparent mistakes on the part of a participating professional person, these questions should be taken up and thoroughly discussed by appropriate committees from the particular professional group to which the practitioner belongs. It should not be necessary to air all questions of supposed irregularities in general healing arts committees, except when more than one branch of the healing arts professions is involved in the particular question under discussion. Nor should a professional person be given a hearing before a wholly disinterested group composed of members of other professions or lay citizens or officials, unless the question under discussion definitely involves these professions and other interests. All official disciplinary measures of major importance should come from the central committees at Harrisburg, but its action should usually be based on the recommendations of the local county professional committee.

11. That all "paper work" be reduced to an absolute minimum, but be of such type as to lend itself to punch-card tabulations and analysis.

It is hoped that only two forms will be necessary to conduct the routine operation of the medical program:

(1) A form of identification for the patient, which will certify his right to participate in the medical program. This must be issued at regular intervals by the relief or assistance authorities, and might be in the form

of a detachable stub on the weekly check, or a separate identification card for those not receiving other assistance;

(2) A case record card to be used by the participating professional people, containing a complete record of the case, and also constituting a bill for services. This card should be of such a type that punch card analysis and tabulations will be possible at any time. Medical and social data thus collected will be of inestimable value in the future.

The use of numerous complicated forms and blanks in the program will not only increase the expense of operation but will work a real hardship on the professional persons participating in it.

12. That a committee, representing the same interests as the committee making this report, should continue to function over a longer period, with official sanction of the State authorities and with financial means to conduct its studies.

Need is apparent for further study of the economic effect of illness on the marginal low-income group; the degree to which governmental agencies meet their assumed obligations to care for the insane, for the tuberculous and for the crippled and convalescent patient; the care of patients with other catastrophic illnesses, such as cancer, diabetes, and syphilis; the extension of laboratory and diagnostic facilities, of rural nursing and of distribution of biological products and certain drugs. Various medico-economic experiments (group hospitalization, pre-payment and post-payment plans) now being conducted in certain communities should be evaluated. The facts concerning the distribution of general hospital facilities, hospital finances and the effective coordination of hospitals with the care of the indigent sick, should have further study. Preventive measures, especially those directed towards improving the health and hygiene of children, merit special consideration.

APPENDIX I

GENERAL TABLES

Table 11

Medical Orders Issued and Approved for Recipients of State Emergency Relief in 1935, Expenditures for Those Approved, and Average Expenditure per Order and Per Case on Relief By Counties

County	Average number of cases on direct and work relief	Total number of medical orders issued to direct and work relief cases	Number of medical orders issued per 1,000 cases on direct and work relief	Total number of medical orders approved	Expenditures for medical orders approved	Average expenditure per medical order approved	Average expenditure for medical orders per case on relief (direct and work)
State Total	453,909	488,268	1,075.7	448,714	$2,323,880.49	$5.18	$5.12
Adams	644	436	677.0	451	4,671.00	10.36	7.25
Allegheny	84,386	89,758	1,063.7	91,379	429,691.25	4.70	5.09
Armstrong	3,150	3,213	1,020.0	3,620	19,459.42	5.38	6.18
Beaver	6,497	7,550	1,162.1	7,469	42,035.00	5.63	6.47
Bedford	2,169	3,228	1,488.2	3,286	18,860.48	5.74	8.70
Berks	7,177	6,572	915.7	5,823	34,717.25	5.96	4.84
Blair	5,468	6,794	1,242.5	6,500	38,633.00	5.94	7.07
Bradford	1,083	1,037	957.5	914	6,196.75	6.78	5.72
Bucks	1,928	2,067	1,072.1	2,183	10,998.00	5.04	5.70
Butler	3,152	3,633	1,152.6	3,498	21,339.58	6.10	6.77
Cambria	9,390	13,127	1,398.0	12,595	77,883.80	6.18	8.29
Cameron	128	46	359.4	35	402.00	11.49	3.14
Carbon	2,475	3,748	1,514.3	3,648	15,115.00	4.14	6.11
Centre	2,199	3,588	1,631.7	3,395	16,700.50	4.92	7.59
Chester	2,841	3,414	1,201.7	3,212	16,797.69	5.23	5.91
Clarion	1,339	2,344	1,750.6	2,282	15,925.00	6.98	11.89
Clearfield	6,481	13,349	2,059.7	14,192	59,905.19	4.22	9.24
Clinton	1,539	5,998	3,897.3	4,272	21,807.00	5.10	14.17
Columbia	2,773	3,703	1,335.4	4,403	29,515.00	6.70	10.64
Crawford	2,283	1,712	749.9	1,287	6,397.50	4.97	2.80
Cumberland	2,151	1,852	768.0	1,850	10,835.75	6.57	5.04
Dauphin	6,442	4,241	658.3	3,497	25,905.51	7.41	4.02
Delaware	6,355	3,737	588.0	3,408	22,931.25	6.73	3.61
Elk	995	1,035	1,040.2	1,066	8,350.12	7.83	8.39
Erie	7,978	10,618	1,330.9	9,660	36,509.00	3.78	4.58
Fayette	14,380	30,478	2,119.5	26,707	96,261.00	3.60	6.69
Forest	211	121	573.5	90	767.00	8.52	3.64
Franklin	1,940	1,543	795.4	1,466	11,203.00	7.64	5.77
Fulton	456	316	693.0	298	2,021.00	6.78	4.43
Greene	2,212	3,237	1,463.4	3,394	17,101.19	5.04	7.73
Huntingdon	2,179	2,711	1,244.1	2,610	15,663.00	6.00	7.19
Indiana	3,836	4,712	1,228.4	4,288	21,125.00	4.93	5.51
Jefferson	2,661	3,416	1,283.7	3,674	23,026.50	6.27	8.65
Juniata	639	767	1,200.3	702	4,381.25	6.24	6.86
Lackawanna	17,752	17,784	1,001.8	15,626	90,175.00	5.77	5.08
Lancaster	5,980	5,742	960.2	5,501	35,279.50	6.41	5.90
Lawrence	5,847	6,919	1,183.3	5,729	18,932.75	3.30	3.24
Lebanon	1,727	1,658	960.0	1,482	11,273.10	7.61	6.53
Lehigh	7,573	10,095	1,332.1	8,664	34,976.00	4.04	4.62
Luzerne	24,263	33,451	1,378.7	34,888	178,956.50	5.13	7.38
Lycoming	4,567	10,160	2,224.7	8,137	39,092.00	4.80	8.56
McKean	1,407	1,622	1,152.8	1,376	8,678.00	6.31	6.17
Mercer	4,618	6,392	1,384.1	6,166	34,596.50	5.61	7.49
Mifflin	1,587	2,728	1,719.0	2,687	15,086.00	5.61	9.51
Monroe	1,148	997	868.5	878	6,604.00	7.52	5.75
Montgomery	4,924	4,917	998.6	5,141	32,113.50	6.25	6.52
Montour	824	829	1,006.1	894	5,569.25	6.23	6.76
Northampton	7,236	9,631	1,331.0	8,721	38,166.50	4.38	5.27
Northumberland	7,322	9,377	1,280.7	8,331	51,123.25	6.14	6.98
Perry	738	862	1,168.0	786	5,450.30	6.93	7.39
Philadelphia	103,082	59,769	579.8	40,640	225,006.10	5.54	2.18
Pike	148	46	310.8	32	324.00	10.13	2.19
Potter	831	-	-	-	-	-	-
Schuylkill	13,085	12,062	921.8	10,370	66,222.50	6.39	5.06
Snyder	1,016	921	906.5	814	5,792.25	7.12	5.70
Somerset	4,783	4,741	991.2	5,003	31,811.50	6.36	6.65
Sullivan	250	336	1,344.0	267	1,941.50	7.27	7.77
Susquehanna	1,306	1,906	1,459.4	1,594	9,960.00	6.25	7.63
Tioga	850	758	891.8	438	3,687.50	7.56	4.34
Union	776	800	1,030.9	729	5,202.50	7.14	6.70
Venango	3,623	6,150	1,697.5	4,973	22,492.00	4.52	6.21
Warren	1,540	2,018	1,310.4	1,894	10,603.29	5.60	6.89
Washington	7,717	7,582	982.5	6,943	42,004.97	6.05	5.44
Wayne	802	613	764.3	454	3,377.00	7.44	4.21
Westmoreland	12,017	17,484	1,454.9	17,009	72,411.50	4.26	6.03
Wyoming	681	1,080	1,585.9	874	5,029.00	5.75	7.38
York	4,347	4,937	1,135.7	4,669	28,831.75	6.18	6.63

Table 12

Dental Orders Approved for Recipients of State Emergency Relief in 1935, Expenditures for the Orders, and Average Expenditure per Order and per Case on Relief
By Counties

County	Average number of cases on direct and work relief	Total number of dental orders approved	Number of dental orders per 1,000 cases on direct and work relief	Expenditures for dental orders approved	Average expenditure per dental order approved	Average expenditure for dental orders per case on relief (direct and work)
State Total	453,909	136,403	300.5	$481,588.40	$3.53	$1.06
Adams	644	61	94.7	270.00	4.43	0.42
Allegheny	84,386	30,267	358.7	127,949.00	4.23	1.52
Armstrong	3,150	1,102	349.8	3,397.00	3.08	1.08
Beaver	6,497	2,106	324.1	6,827.50	3.24	1.05
Bedford	2,169	1,056	486.9	4,001.75	3.79	1.84
Berks	7,177	1,501	209.1	6,244.00	4.16	0.87
Blair	5,468	2,297	420.1	7,779.00	3.39	1.42
Bradford	1,083	300	277.0	845.75	2.82	0.78
Bucks	1,928	460	238.6	1,527.00	3.32	0.79
Butler	3,152	985	312.5	3,156.50	3.20	1.00
Cambria	9,390	3,107	330.9	13,108.50	4.22	1.40
Cameron	128	14	109.4	57.00	4.07	0.45
Carbon	2,475	975	393.9	2,317.00	2.38	0.94
Centre	2,199	1,179	536.2	4,121.50	3.50	1.87
Chester	2,841	462	162.6	1,289.00	2.79	0.45
Clarion	1,339	423	315.9	1,693.50	4.00	1.26
Clearfield	6,461	3,475	536.2	12,500.50	3.60	1.93
Clinton	1,539	1,217	790.8	4,951.50	4.07	3.22
Columbia	2,773	1,347	485.8	4,645.00	3.45	1.68
Crawford	2,283	509	223.0	2,228.00	4.38	0.98
Cumberland	2,151	356	165.5	1,298.50	3.65	0.60
Dauphin	6,442	1,663	256.1	5,944.25	3.57	0.92
Delaware	6,355	651	102.4	2,714.00	4.17	0.43
Elk	995	514	516.6	1,805.50	3.51	1.81
Erie	7,978	2,037	255.3	4,737.25	2.33	0.59
Fayette	14,380	7,198	500.6	21,817.75	3.03	1.52
Forest	211	28	132.7	86.50	3.09	0.41
Franklin	1,940	585	301.5	2,226.50	3.81	1.15
Fulton	456	73	160.1	292.00	4.00	0.64
Greene	2,212	801	362.1	2,173.50	2.71	0.98
Huntingdon	2,179	987	453.0	3,691.00	3.74	1.69
Indiana	3,836	1,863	485.7	5,791.00	3.11	1.51
Jefferson	2,661	1,425	535.5	4,873.50	3.42	1.83
Juniata	639	168	262.9	712.75	4.24	1.12
Lackawanna	17,752	6,551	369.0	19,305.00	2.95	1.09
Lancaster	5,980	1,024	171.2	4,136.25	4.04	0.69
Lawrence	5,847	3,088	528.1	8,434.00	2.73	1.44
Lebanon	1,727	353	204.4	1,331.90	3.77	0.77
Lehigh	7,578	1,424	187.9	3,403.50	2.39	0.45
Luzerne	24,263	14,304	589.5	46,591.00	3.26	1.92
Lycoming	4,567	1,774	388.4	5,478.50	3.09	1.20
McKean	1,407	370	263.0	1,084.00	2.93	0.77
Mercer	4,618	2,171	470.1	10,636.00	4.90	2.30
Mifflin	1,587	716	451.2	2,119.50	2.98	1.34
Monroe	1,148	210	182.9	900.00	4.29	0.78
Montgomery	4,924	816	165.7	2,147.00	2.63	0.44
Montour	824	365	443.0	1,061.00	2.91	1.29
Northampton	7,236	1,247	172.3	2,921.50	2.34	0.40
Northumberland	7,322	2,225	303.9	5,980.00	2.69	0.82
Perry	738	176	238.5	781.75	4.44	1.06
Philadelphia	103,082	8,469	82.2	34,374.00	4.06	0.33
Pike	148	11	74.3	39.00	3.55	0.26
Potter	831	-	-	-	-	-
Schuylkill	13,085	4,599	351.5	10,966.50	2.38	0.84
Snyder	1,016	229	225.4	910.50	3.98	0.90
Somerset	4,783	2,190	457.9	11,632.00	5.31	2.43
Sullivan	250	108	432.0	306.50	2.84	1.23
Susquehanna	1,306	552	422.7	2,332.50	4.23	1.79
Tioga	850	187	220.0	773.50	4.14	0.91
Union	776	158	203.6	421.00	2.66	0.54
Venango	3,623	1,567	432.5	4,549.00	2.90	1.26
Warren	1,540	790	513.0	3,681.50	4.66	2.39
Washington	7,717	2,628	340.5	7,581.00	2.88	0.98
Wayne	802	262	326.7	1,164.00	4.44	1.45
Westmoreland	12,017	5,090	423.6	13,000.00	2.55	1.08
Wyoming	681	363	533.0	1,319.25	3.63	1.94
York	4,347	1,194	274.7	5,154.25	4.32	1.19

Table 13

Nursing Orders Approved for Recipients of State Emergency Relief in 1935, Expenditure for the Orders, and Average Expenditure per Order and Per Case on Relief
By Counties

County	Average number of cases on direct and work relief	Total number of nursing orders approved	Number of nursing orders approved per 1,000 cases on direct and work relief	Expenditure for nursing orders approved	Average expenditure per nursing order approved	Average expenditure for nursing orders per case on relief (direct and work)
State Total	453,909	13,664	30.1	$86,057.69	$6.30	$0.19
Adams	644	1	1.6	8.50	8.50	0.01
Allegheny	84,386	2,945	34.9	20,101.65	6.83	0.24
Armstrong	3,150	63	20.0	419.90	6.67	0.13
Beaver	6,497	72	12.1	551.65	7.66	0.08
Bedford	2,169	120	55.3	925.50	7.71	0.43
Berks	7,177	204	28.4	1,097.35	5.38	0.15
Blair	5,468	199	36.4	1,642.20	8.25	0.30
Bradford	1,083	12	11.1	92.65	7.72	0.09
Bucks	1,928	8	4.1	51.69	6.46	0.03
Butler	3,152	37	11.7	259.25	7.01	0.08
Cambria	9,390	646	68.8	4,911.90	7.60	0.52
Cameron	128	-	-	-	-	-
Carbon	2,475	2	0.8	13.60	6.80	0.01
Centre	2,199	61	27.7	1,403.81	23.01	0.64
Chester	2,841	146	51.4	936.70	6.42	0.33
Clarion	1,339	4	3.0	27.20	6.80	0.02
Clearfield	6,481	371	57.2	2,724.20	7.34	0.42
Clinton	1,539	103	66.9	831.30	8.07	0.54
Columbia	2,773	45	16.2	340.85	7.57	0.12
Crawford	2,283	20	8.8	153.00	7.65	0.07
Cumberland	2,151	37	17.2	294.10	7.95	0.14
Dauphin	6,442	148	23.0	1,008.95	6.82	0.16
Delaware	6,355	455	71.6	2,552.55	5.61	0.40
Elk	995	7	7.0	59.00	8.43	0.06
Erie	7,978	775	97.1	2,591.68	3.34	0.32
Fayette	14,380	650	45.2	4,172.91	6.42	0.29
Forest	211	2	9.5	7.65	3.83	0.04
Franklin	1,940	1	0.5	8.50	8.50	0.00
Fulton	456	-	-	-	-	-
Greene	2,212	131	59.2	862.75	6.59	0.39
Huntingdon	2,179	71	32.6	546.75	7.70	0.25
Indiana	3,836	153	39.9	1,214.65	7.94	0.32
Jefferson	2,661	61	22.9	441.15	7.23	0.17
Juniata	639	-	-	-	-	-
Lackawanna	17,752	1,589	89.5	8,048.65	5.07	0.45
Lancaster	5,980	192	32.1	1,239.30	6.45	0.21
Lawrence	5,847	41	7.0	231.85	5.65	0.04
Lebanon	1,727	146	84.5	923.95	6.33	0.54
Lehigh	7,578	15	2.0	103.70	6.91	0.01
Luzerne	24,263	750	30.9	5,214.20	6.95	0.21
Lycoming	4,567	67	14.7	479.75	7.16	0.11
McKean	1,407	13	9.2	96.05	7.39	0.07
Mercer	4,618	37	8.0	289.00	7.81	0.06
Mifflin	1,587	-	-	-	-	-
Monroe	1,148	48	41.8	285.60	5.95	0.25
Montgomery	4,924	136	27.6	833.05	6.13	0.17
Montour	824	19	23.1	158.10	8.32	0.19
Northampton	7,236	95	13.1	578.55	6.09	0.08
Northumberland	7,322	148	20.2	1,154.00	7.80	0.16
Perry	738	-	-	-	-	-
Philadelphia	103,082	1,579	15.3	8,290.40	5.25	0.08
Pike	148	1	6.8	8.50	8.50	0.06
Potter	831	-	-	-	-	-
Schuylkill	13,085	49	3.7	356.15	7.27	0.03
Snyder	1,016	2	2.0	17.00	8.50	0.02
Somerset	4,783	202	42.2	1,582.70	7.84	0.33
Sullivan	250	9	36.0	62.05	6.89	0.25
Susquehanna	1,306	12	9.2	64.95	5.41	0.05
Tioga	850	3	3.5	25.50	8.50	0.03
Union	776	2	2.6	17.00	8.50	0.02
Venango	3,623	124	34.2	1,026.80	8.28	0.28
Warren	1,540	9	5.8	56.95	6.33	0.04
Washington	7,717	58	7.5	442.40	7.63	0.06
Wayne	802	34	42.4	260.10	7.65	0.32
Westmoreland	12,017	301	25.0	2,359.90	7.84	0.20
Wyoming	681	8	11.7	68.00	8.50	0.10
York	4,347	425	97.8	1,530.00	3.60	0.35

Table 14

Prescription Orders Approved for Recipients of State Emergency Relief in 1935, Expenditures for the Orders, and Average Expenditure per Order and per Case on Relief
By Counties

County	Average number of cases on direct and work relief	Total number of prescription orders approved	Number of prescription orders approved per 1,000 cases on direct and work relief	Expenditures for prescription orders approved	Average expenditure per prescription order approved	Average expenditure for prescription orders per case on relief (direct and work)
State Total	453,909	484,517	1,067.4	$238,099.74	$0.49	$0.52
Adams	644	72	111.8	32.70	0.45	0.05
Allegheny	84,386	143,708	1,703.0	69,338.94	0.48	0.82
Armstrong	3,150	4,012	1,273.7	2,001.10	0.50	0.64
Beaver	6,497	4,737	729.1	2,233.50	0.47	0.34
Bedford	2,169	735	338.9	376.30	0.51	0.17
Berks	7,177	410	57.1	215.13	0.52	0.03
Blair	5,468	792	144.8	420.40	0.53	0.08
Bradford	1,083	333	307.5	157.55	0.47	0.15
Bucks	1,928	493	255.7	175.79	0.36	0.09
Butler	3,152	4,303	1,365.2	2,744.75	0.64	0.87
Cambria	9,390	10,298	1,096.7	5,038.46	0.49	0.54
Cameron	128	17	132.8	8.69	0.51	0.07
Carbon	2,475	254	102.6	123.50	0.49	0.05
Centre	2,199	1,897	862.7	1,046.55	0.55	0.48
Chester	2,841	958	337.2	431.12	0.45	0.15
Clarion	1,339	72	53.8	41.75	0.58	0.03
Clearfield	6,481	7,803	1,204.0	4,132.22	0.53	0.64
Clinton	1,539	5,120	3,326.8	2,458.43	0.48	1.60
Columbia	2,773	2,188	789.0	1,253.29	0.57	0.45
Crawford	2,283	354	155.1	174.89	0.49	0.08
Cumberland	2,151	67	31.1	26.49	0.40	0.01
Dauphin	6,442	856	132.9	379.94	0.44	0.06
Delaware	6,355	3,312	521.2	1,579.28	0.48	0.25
Elk	995	679	682.4	319.88	0.47	0.32
Erie	7,978	4,442	556.8	2,276.24	0.51	0.29
Fayette	14,380	18,143	1,261.7	12,858.56	0.71	0.89
Forest	211	13	61.6	6.15	0.47	0.03
Franklin	1,940	107	55.2	84.27	0.79	0.04
Fulton	456	1	2.2	2.09	2.09	0.00
Greene	2,212	1,027	464.3	489.39	0.48	0.22
Huntingdon	2,179	44	20.2	23.25	0.53	0.01
Indiana	3,836	3,926	1,023.5	1,715.31	0.44	0.45
Jefferson	2,661	3,057	1,148.8	1,527.91	0.50	0.57
Juniata	639	5	7.8	53.10	10.62	0.08
Lackawanna	17,752	30,740	1,731.6	15,698.29	0.51	0.88
Lancaster	5,980	1,853	309.9	1,022.17	0.55	0.17
Lawrence	5,847	9,658	1,651.8	4,690.80	0.49	0.80
Lebanon	1,727	459	265.8	169.75	0.37	0.10
Lehigh	7,578	169	22.3	264.05	1.56	0.03
Luzerne	24,263	51,723	2,131.8	23,580.56	0.46	0.97
Lycoming	4,567	9,929	2,174.1	4,403.31	0.44	0.96
McKean	1,407	1,413	1,004.3	700.30	0.50	0.50
Mercer	4,618	4,349	941.7	2,207.37	0.51	0.48
Mifflin	1,587	111	69.9	64.39	0.58	0.04
Monroe	1,148	158	137.6	137.99	0.87	0.12
Montgomery	4,924	2,470	501.6	1,151.65	0.47	0.23
Montour	824	77	93.4	65.65	0.85	0.08
Northampton	7,236	606	83.7	430.62	0.71	0.06
Northumberland	7,322	10,071	1,375.4	5,376.20	0.53	0.73
Perry	738	-	-	-	-	-
Philadelphia	103,082	103,490	1,004.0	49,239.45	0.48	0.48
Pike	148	17	114.9	9.94	0.58	0.07
Potter	831	-	-	-	-	-
Schuylkill	13,085	8,292	633.7	4,166.53	0.50	0.32
Snyder	1,016	79	77.8	38.85	0.49	0.04
Somerset	4,783	437	91.4	350.01	0.80	0.07
Sullivan	250	188	752.0	93.60	0.50	0.37
Susquehanna	1,306	774	592.6	400.53	0.52	0.31
Tioga	850	43	50.6	26.83	0.62	0.03
Union	776	3	3.9	1.35	0.45	0.00
Venango	3,623	2,611	720.7	1,320.15	0.51	0.36
Warren	1,540	1,844	1,197.4	889.74	0.48	0.58
Washington	7,717	5,479	710.0	2,336.52	0.43	0.30
Wayne	802	89	111.0	52.75	0.59	0.07
Westmoreland	12,017	12,151	1,011.2	4,906.59	0.40	0.41
Wyoming	681	70	102.8	99.01	1.41	0.15
York	4,347	929	213.7	457.87	0.49	0.11

Table 15

Total Orders Approved for Health Work* for Recipients of State Emergency Relief in 1935, Expenditures for the Orders, and Average Expenditures per Order and per Case on Relief
By Counties

County	Average number of cases on direct and work relief	Total number of orders approved for health work of S.E.R.B. cases	Number of orders approved for health work per 1,000 cases on direct and work relief	Total expenditures for all orders approved for health work	Average expenditure per order approved for health work	Average expenditure per case on relief (direct and work) for orders approved for health work
State Total	453,909	1,083,298	2,386.6	$3,129,626.32	$2.89	$6.89
Adams	644	585	908.4	4,982.20	8.52	7.74
Allegheny	84,386	268,299	3,179.4	647,080.84	2.41	7.67
Armstrong	3,150	8,797	2,792.7	25,277.42	2.87	8.02
Beaver	6,497	14,384	2,213.9	51,647.65	3.59	7.95
Bedford	2,169	5,197	2,396.0	24,164.03	4.65	11.14
Berks	7,177	7,938	1,106.0	42,273.73	5.33	5.89
Blair	5,468	9,788	1,790.1	48,474.60	4.95	8.87
Bradford	1,083	1,559	1,439.5	7,292.70	4.68	6.73
Bucks	1,928	3,144	1,630.7	12,752.48	4.06	6.61
Butler	3,152	8,823	2,799.2	27,500.08	3.12	8.72
Cambria	9,390	26,646	2,837.7	100,922.66	3.79	10.75
Cameron	128	66	515.6	467.69	7.09	3.65
Carbon	2,475	4,879	1,971.3	17,569.10	3.60	7.10
Centre	2,199	6,532	2,970.4	23,272.36	3.56	10.58
Chester	2,841	4,778	1,681.8	19,454.51	4.07	6.85
Clarion	1,339	2,781	2,076.9	17,687.45	6.36	13.21
Clearfield	6,491	25,841	3,987.2	79,262.11	3.07	12.23
Clinton	1,539	10,712	6,960.4	30,048.23	2.81	19.52
Columbia	2,773	7,983	2,878.8	35,754.14	4.48	12.89
Crawford	2,283	2,170	950.5	8,953.39	4.13	3.92
Cumberland	2,151	2,110	980.9	12,454.84	5.90	5.79
Dauphin	6,442	6,164	956.8	33,238.65	5.39	5.16
Delaware	6,355	7,826	1,231.5	29,777.08	3.80	4.69
Elk	995	2,266	2,277.4	10,534.50	4.65	10.59
Erie	7,978	16,914	2,120.1	46,114.17	2.73	5.78
Fayette	14,380	52,698	3,664.7	135,110.22	2.56	9.40
Forest	211	133	630.3	867.30	6.52	4.11
Franklin	1,940	2,159	1,112.9	13,522.27	6.26	6.97
Fulton	456	372	815.8	2,315.09	6.22	5.08
Greene	2,212	5,353	2,420.0	20,626.83	3.85	9.32
Huntingdon	2,179	3,712	1,703.5	19,924.00	5.37	9.14
Indiana	3,836	10,230	2,666.8	29,845.96	2.92	7.78
Jefferson	2,661	8,217	3,087.9	29,869.06	3.64	11.22
Juniata	639	875	1,369.3	5,147.10	5.88	8.05
Lackawanna	17,752	54,506	3,070.4	133,226.94	2.44	7.50
Lancaster	5,980	8,570	1,433.1	41,677.22	4.86	6.97
Lawrence	5,847	18,516	3,166.8	32,289.40	1.74	5.52
Lebanon	1,727	2,440	1,412.9	13,698.70	5.61	7.93
Lehigh	7,578	10,272	1,355.5	38,747.25	3.77	5.11
Luzerne	24,263	101,665	4,190.1	254,342.26	2.50	10.48
Lycoming	4,567	19,907	4,358.9	49,453.56	2.48	10.83
McKean	1,407	3,172	2,254.4	10,558.35	3.33	7.50
Mercer	4,618	12,723	2,755.1	47,728.87	3.75	10.34
Mifflin	1,587	3,514	2,214.2	17,269.89	4.91	10.88
Monroe	1,148	1,294	1,127.2	7,927.59	6.13	6.91
Montgomery	4,924	8,563	1,739.0	36,245.20	4.23	7.36
Montour	824	1,355	1,644.4	6,854.00	5.06	8.32
Northampton	7,236	10,669	1,474.4	42,097.17	3.95	5.82
Northumberland	7,322	20,775	2,837.3	63,633.45	3.06	8.69
Perry	738	962	1,303.5	6,232.05	6.48	8.44
Philadelphia	103,082	154,178	1,495.7	316,909.95	2.06	3.07
Pike	148	61	412.2	381.44	6.25	2.58
Potter	831	-	-	-	-	-
Schuylkill	13,085	23,310	1,781.4	81,711.68	3.51	6.24
Snyder	1,016	1,124	1,106.3	6,758.60	6.01	6.65
Somerset	4,783	7,832	1,637.5	45,376.21	5.79	9.49
Sullivan	250	572	2,288.0	2,403.65	4.20	9.61
Susquehanna	1,306	2,932	2,245.0	12,757.98	4.35	9.77
Tioga	850	721	848.2	4,513.33	6.26	5.31
Union	776	892	1,149.5	5,641.85	6.32	7.27
Venango	3,823	9,275	2,560.0	29,387.95	3.17	8.11
Warren	1,540	4,537	2,946.1	15,231.48	3.36	9.89
Washington	7,717	15,108	1,957.8	52,364.89	3.47	6.79
Wayne	802	839	1,046.1	4,853.85	5.79	6.05
Westmoreland	12,017	34,551	2,875.2	92,677.99	2.68	7.71
Wyoming	681	1,315	1,931.0	6,515.26	4.95	9.57
York	4,347	7,217	1,660.2	35,973.87	4.98	8.28

*Including medical, dental, nursing, and prosoription orders.

Table 16

Free Hospital Service and Facilities in Pennsylvania

Number of Beds, Number of Days of Free Care in General Hospitals, Number of Out-patient Visits to General Hospitals and Visits to State and City Health Department Clinics in 1935, per 1,000 Population

By Counties

Counties	Estimated population July 1, 1935(1)	Number of beds in general hospitals(2)	Beds for each 1,000 population	Number of beds in mental institutions	Number of beds in tuberculosis institutions(3)	Number of beds in other hospitals(4)	Total number of beds	Beds for each 1,000 population	Number of days of free care in general hospitals(5)	Number of days of free care in general hospitals per 1,000 of population	Number of out-patient visits to general hospitals(6)	Number of visits to State and City Health department Clinics(6)	Total number of clinic visits	Clinic visits per 1,000 of population	Counties
State total	10,066,000	39,861	3.96	35,105	4,254	9,047	88,267	8.77	5,734,462	569.7	3,438,618	779,681	4,218,299	419.1	State total
Adams	38,800	60	1.55	-	-	-	60	1.55	2,078	53.6	1,380	325	1,705	43.9	Adams
Allegheny	1,436,400	9,836	6.85	1,145	450	4,501	15,932	11.09	1,891,494	1,316.8	397,985	63,086	461,071	321.0	Allegheny
Armstrong	82,900	55	0.66	-	-	-	55	0.66	5,450	65.7	-	3,582	3,582	43.2	Armstrong
Beaver	155,800	244	1.57	-	63	130	437	2.80	15,056	96.6	5,645	1,471	7,116	45.7	Beaver
Bedford	39,000	-	-	-	-	-	-	-	-	-	-	3,692	3,692	94.7	Bedford
Berks	242,200	587	2.42	-	134	-	721	2.98	79,271	327.3	100,273	59,145	159,418	658.2	Berks
Blair	146,200	367	2.51	300	-	-	667	4.56	27,432	187.6	25,198	2,935	28,133	192.4	Blair
Bradford	51,300	325	6.34	-	-	-	325	6.34	40,430	788.1	28,378	-	28,378	553.2	Bradford
Bucks	101,100	121	1.20	-	-	-	121	1.20	6,400	63.3	1,070	1,028	2,098	20.8	Bucks
Butler	84,100	102	1.21	-	-	52	154	1.83	6,699	79.7	960	135	1,095	13.0	Butler
Cambria	212,300	648	3.05	-	-	70	718	3.38	66,078	311.2	14,516	4,242	18,758	88.4	Cambria
Cameron	5,500	-	-	-	-	-	-	-	-	-	-	172	172	31.3	Cameron
Carbon	66,200	75	1.13	-	-	-	75	1.13	5,450	82.3	3,394	635	4,029	60.9	Carbon
Centre	48,400	76	1.57	-	-	29	105	2.17	9,248	191.1	1,192	1,728	2,920	60.3	Centre
Chester	132,300	403	3.05	315	-	140	858	6.49	34,496	260.7	19,239	5,251	24,490	185.1	Chester
Clarion	36,100	-	-	-	-	-	-	-	-	-	-	763	763	21.1	Clarion
Clearfield	90,600	266	2.94	-	-	-	266	2.94	9,429	104.1	1,986	4,245	6,231	68.8	Clearfield
Clinton	33,800	124	3.67	-	-	-	124	3.67	9,112	269.6	3,394	58	3,452	102.1	Clinton
Columbia	51,000	195	3.82	-	-	-	195	3.82	15,929	312.3	3,893	942	4,835	94.8	Columbia
Crawford	65,800	263	4.00	-	-	-	263	4.00	17,535	266.5	6,110	1,516	7,626	115.9	Crawford
Cumberland	71,300	100	1.40	-	-	-	100	1.40	5,356	75.1	3,655	980	4,635	65.0	Cumberland
Dauphin	172,700	445	2.58	-	-	35	460	2.78	45,415	263.0	79,514	3,703	83,217	481.9	Dauphin
Delaware	292,900	805	2.75	-	-	125	930	3.18	56,665	193.5	44,666	2,666	47,332	161.6	Delaware
Elk	34,900	136	3.90	-	-	-	136	3.90	3,842	110.1	262	282	544	15.6	Elk
Erie	183,200	484	2.64	-	53	164	701	3.83	67,164	366.6	32,187	12,116	44,303	241.8	Erie
Fayette	207,500	325	1.57	-	-	-	325	1.57	31,996	154.2	24,823	3,372	28,195	135.9	Fayette
Forest	5,400	-	-	-	-	-	-	-	-	-	-	458	458	84.8	Forest
Franklin	67,900	135	1.99	-	-	-	135	1.99	9,377	138.1	4,200	1,329	5,529	81.4	Franklin
Fulton	9,600	-	-	-	-	-	-	-	-	-	-	22	22	2.3	Fulton
Greene	43,700	40	0.92	-	-	-	40	0.92	3,479	79.6	-	847	847	19.4	Greene
Huntingdon	40,800	84	2.06	-	-	36	120	2.94	8,996	220.5	-	2,310	2,310	56.6	Huntingdon
Indiana	78,800	154	1.95	-	-	-	154	1.95	16,328	207.2	2,002	643	2,645	33.6	Indiana
Jefferson	54,500	130	2.39	-	-	-	130	2.39	10,305	189.1	-	988	988	18.1	Jefferson
Juniata	15,000	-	-	-	-	-	-	-	-	-	-	392	392	26.1	Juniata
Lackawanna	324,400	806	2.48	1,474	140	249	2,669	8.23	84,578	260.7	30,694	59,451	90,145	277.9	Lackawanna
Lancaster	205,800	696	3.38	408	55	-	1,159	5.63	60,812	295.5	46,656	4,078	50,734	246.5	Lancaster
Lawrence	101,600	348	3.43	-	-	-	348	3.43	20,130	198.1	-	5,554	5,554	54.7	Lawrence
Lebanon	70,100	156	2.23	-	-	-	156	2.23	17,834	254.4	5,456	2,248	7,704	109.9	Lebanon
Lehigh	180,700	625	3.46	-	-	-	625	3.46	63,664	352.3	67,016	17,976	84,992	470.3	Lehigh
Luzerne	465,200	1,678	3.61	1,000	250	16	2,944	6.33	320,310	688.5	62,985	28,828	91,813	197.4	Luzerne
Lycoming	97,600	325	3.33	-	-	-	325	3.33	28,296	289.9	7,197	1,331	8,528	87.4	Lycoming
McKean	67,700	232	4.02	-	-	-	232	4.02	11,429	198.1	2,895	-	2,895	50.2	McKean
Mercer	103,700	217	2.09	342	-	-	559	5.39	14,542	140.2	4,323	1,146	5,469	52.7	Mercer
Mifflin	42,200	93	2.20	-	-	-	93	2.20	5,450	129.1	3,394	2,329	5,723	135.6	Mifflin
Monroe	29,600	59	1.99	-	-	-	59	1.99	3,764	127.2	3,394	2,319	5,713	193.0	Monroe
Montgomery	277,800	872	3.14	-	288	125	1,285	4.63	54,972	197.9	49,421	3,262	62,683	189.6	Montgomery
Montour	15,200	182	11.97	-	-	-	182	11.97	8,278	544.6	10,278	1,841	12,119	797.3	Montour
Northampton	176,900	430	2.43	-	-	-	430	2.43	74,327	420.2	41,909	2,291	44,200	249.9	Northampton
Northumberland	134,300	79	0.59	-	-	-	79	0.59	9,347	69.6	537	10,356	10,893	81.1	Northumberland
Perry	22,700	-	-	-	-	24	24	1.06	-	-	-	-	-	-	Perry
Philadelphia	2,039,000	11,892	5.83	6,631	272	2,741	21,536	10.56	1,638,043	803.4	1,939,563	416,300	2,355,863	1,155.4	Philadelphia
Pike	7,800	-	-	-	-	-	-	-	-	-	-	-	-	-	Pike
Potter	18,300	35	1.91	-	-	-	35	1.91	2,224	121.5	-	-	-	-	Potter
Schuylkill	246,100	373	1.52	495	-	-	868	3.53	65,642	266.7	3,671	4,230	7,901	32.1	Schuylkill
Snyder	19,700	-	-	-	-	-	-	-	-	-	-	332	332	16.9	Snyder
Somerset	84,400	153	1.81	541	-	-	694	8.22	13,993	165.8	11,150	555	11,705	138.7	Somerset
Sullivan	7,800	-	-	-	-	-	-	-	-	-	-	-	-	-	Sullivan
Susquehanna	35,300	21	0.59	-	-	-	21	0.59	2,224	63.0	-	650	650	18.4	Susquehanna
Tioga	33,300	-	-	-	-	-	-	-	-	-	-	199	199	6.0	Tioga
Union	18,300	30	1.64	-	104	-	134	7.32	2,224	121.5	-	-	-	-	Union
Venango	66,100	152	2.30	-	50	-	202	3.06	8,917	134.9	3,352	2,362	5,714	86.4	Venango
Warren	43,300	102	2.36	-	-	-	102	2.36	6,183	142.8	1,901	1,703	3,604	83.2	Warren
Washington	214,000	318	1.49	-	-	-	318	1.49	20,531	95.9	12,387	999	13,386	62.6	Washington
Wayne	29,700	36	1.21	-	-	-	36	1.21	902	30.4	102	-	102	3.4	Wayne
Westmoreland	308,300	395	1.28	-	-	-	395	1.28	39,856	129.3	12,430	1,257	13,687	44.4	Westmoreland
Wyoming	16,200	-	-	-	-	-	-	-	-	-	-	916	916	56.5	Wyoming
York	174,700	282	1.61	-	-	-	282	1.61	32,524	186.2	13,534	22,109	35,643	204.0	York
State wide institutions		2,689		22,454	2,395	610	28,148		622,957		,298,451		298,451		State wide institutions

(1.) Estimated as of July 1, 1935 by the Pennsylvania Department of Public Health.
(2.) Data from 1936 Edition of the American Medical Association Diractory, proprietary hospitals excluded.
(3.) The Pennsylvania Tuberculosis Association states that there were 8,336 beds in Pennsylvania for the care of tuberculosis, including those in civilian and non-civilian hospitals, sanatoria, and preventoria in 1936.
(4.) These other hospitals include beds in hospitals especially caring for children; convalescent and rest patients; drug and alcoholic patients; epileptic patients; eye, ear, nose, and throat patients; aged persons; incurables; isolation needs; maternity needs; orthopedic; prison and reformatory inmates; school infirmries; skin and cancer; and venereal disease patients.
(5.) Data for the most part from schedules of the Pennsylvania Hospital Association.
(6.) Visits to health department clinics in general hospitals accounted for in the Pennsylvania Hospital Association schedules excluded in order to avoid duplication.

Table 15

Total Orders Approved for Health Work* for Recipients of State Emergency Relief in 1935,

York 4,547

*Including medical, dental, nursing, and prescription orders.

APPENDIX II

MONTGOMERY COUNTY AGREEMENT

Rules and Regulations Governing the Medical Treatment

of the Poor of Montgomery County

Effective January 4, 1937

The subject matter herein stated is to be construed as a set of rules and regulations agreed to on the one part by the Montgomery County Poor District, and on the other by the Montgomery County Medical Society.

The purpose of this agreement is to render adequate medical care and attention to the indigent poor, such as those actually receiving relief from the Montgomery County Poor District, the Montgomery County Emergency Relief Board, Mothers' Assistance Fund of Montgomery County, Old Age Assistance Fund of Montgomery County and children being boarded by the Montgomery County Poor District with the Children's Aid Society of Montgomery County. It is to be distinctly understood that this agreement does not include the children placed with the Montgomery County Children's Aid Society by the Juvenile Court of Montgomery County.

This agreement is not to be interpreted in any way to provide care for the indigent poor who are now in institutions, within or without the County; or to provide medical care for the unemployed who are now, or may be in the future, receiving work relief, be it either through Local Organizations, State Relief, Federal Government or our Hospitals.

These rules and regulations are agreed to so that the poor in each and every section of the County may receive good medical service at reasonable cost. The service rendered shall be of two types:

(a) At the home of the patient.

(b) At the office of the physician.

It is agreed that patients of ambulatory type shall go to the office of a physician in the County. If the patient be confined to bed, the physician shall be called to make the visit at the home.

It shall be the duty of the County Medical Society to have appointed an Advisory Committee to assist the Montgomery County Poor District in the maintenance of proper professional service, to determine the adequacy of the medical care, to supervise, correct and approve of all medical bills prior to their presentation to the Montgomery County Poor District.

In all disputes or misunderstandings as to the care of the patients, written charges of the same shall be submitted to the Montgomery County Poor District who shall have the assistance of the Medical Advisory Committee of the Montgomery County Medical Society in all matters in which the said Montgomery County Poor District desires their aid.

QUALIFICATIONS OF THE RECIPIENTS OF MEDICAL SERVICE

1. All persons known to be on accredited lists of the Montgomery County Poor District, or the Montgomery County Emergency Relief Board,

Mothers' Assistance Fund of Montgomery County, Old Age Assistance Fund of Montgomery County, or Children's Aid Society of Montgomery County, shall be eligible to receive medical aid and attention.

2. In each instance a proper and regular form or order must be issued by the Montgomery County Poor District or their representatives authorizing the Doctor to render medical attention in a given case.

3. Only in a dire emergency shall a physician render a service without being fortified with the above mentioned instructions or orders.

(a) Before second visit is made, a confirmation order must be obtained within 48 hours.

4. In the course of treatment of patients under this regulation, the general facilities available for free care and service in given communities shall be utilized.

5. If it becomes necessary to transfer a patient under treatment to one of the hospitals treating patients from the County, notification should be made to proper representatives of the Montgomery County Poor District before said transfer is made.

6. Only in a dire emergency shall this transfer be made without notification to the proper authorities.

7. When the patient is admitted to the Hospital, the Montgomery County Poor District is no longer responsible for medical services rendered by an individual practicing physician.

8. In order to maintain the traditional family physician relationship, wherever possible, the patient shall be permitted to call the physician of his or her choice, provided the said physician desires to practice under these rules and regulations.

TREATMENT IN ACUTE ILLNESS

1. In cases acutely ill, medical care shall be limited to not more than two weeks or ten visits, with a maximum fee of twenty dollars ($20.00) for that service. Any physician accepting a case must continue to treat such a patient, if necessary, until the case is completed.

2. During the period of time in treating a patient under the maximum fee limitation, the physician shall furnish a reasonable amount of drugs and combination of drugs to aid and assist in the recovery of the patient.

3. If any unusual medicines are required, they shall be authorized only after proper request is made to the Montgomery County Poor District or such other agents as they may delegate.

4. Under these rules and regulations, the treatment of patients shall mean:

(a) The diagnosis.

(b) The management.

(c) The furnishing of reasonable medicines and supplies.

TREATMENT IN CHRONIC ILLNESS

1. Prolonged chronic illnesses, such as chronic heart, chronic asthma, chronic rheumatism, or diabetes, or any disease which has continued over a period of time with only a moderate degree of recession and without a complete recovery, shall be paid for not more than one visit weekly, for not more than eight weeks, or at the request of the Montgomery County Poor District be sent to the County Home.

2. However, if the patient, due to unusual seriousness of the chronic disease, shall need more frequent visits, this individual case shall be submitted for proper determination to the Montgomery County Poor District, or the proper agencies.

3. Insulin if needed shall be requested by the physician from the Montgomery County Poor District, or their agents.

TREATMENT IN OBSTETRICAL CARE

1. Obstetrical care in the home shall be construed to mean:

   (a) At least six pre-natal visits and attention.

   (b) Delivery in the home by the physician.

   (c) At least four post-natal visits.

2. If home conditions involve undue risk, or any conditions of the patient lends more than reasonable seriousness to delivery in the home, the patient shall be requested to submit to delivery in one of the institutions rendering such service to the people in the County, and medical attention by the physician shall cease.

3. In the delivery of the indigent poor in their homes, it shall not be construed, in this regulation, that supplies incident to the delivery, whether they be dressings, cotton or medication, shall be paid for by the Montgomery County Poor District, but all reasonable supplies incident to the delivery shall be furnished by the obstetrician in attendance.

SCHEDULE OF FEES

1. Bills shall be rendered to the Montgomery County Poor District before the First Tuesday of each calendar month, and shall include:

   (a) The number of visits.

   (b) The dates made.

   (c) A diagnosis.

   (d) The condition of the patient at termination of treatment.

   (e) The name and address of the patient.

2. For an authorized home visit, the maximum fee, including medicines and supplies, shall not exceed two dollars ($2.00).

3. For an authorized office visit, the maximum fee shall not exceed one dollar ($1.00) which includes medicines and supplies.

4. For authorized obstetrical care in the home, the maximum fee shall not exceed twenty-five dollars ($25.00) including pre-natal and post-natal care.

EMERGENCY OBSTETRICAL CARE

When the physician is called with the onset of labor the fee shall not exceed fifteen dollars ($15.00). The service must include four post-natal visits.

5. Examinations for commitment of mental cases shall be paid for at the rate of five dollars ($5.00) per physician, two physicians being required.

The above is an AGREEMENT set forth in rules and regulations for the care and attention of the indigent poor in Montgomery County. Said rules and regulations shall establish a working basis between the members of the Montgomery County Medical Society and the Montgomery County Poor District. Other questions as they arise shall be mutually agreed upon by the Montgomery County Medical Society and the Montgomery County Poor District.